

**UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION**

**CARL V. MARSHALL,
AIS#110574**

Plaintiff,
vs.

RICHARD ALLEN, et al. ,
Defendants.

**CIVIL ACTION NO.
206-CV-1131-MHT**

MEDICAL RECORDS SUPPLEMENT
TO AMENDED ANSWER
And
SPECIAL REPORT

Pursuant to this court's Order dated July 10, 2007, Defendants file herewith the entire medical file for petitioner Carl V. Marshall, covering the entire time period in question in petitioners' complaint.

Respectfully submitted,

/s/ Neal P. Conner
NEAL P. CONNER (CONN2024)
ASSISTANT GENERAL COUNSEL

ADDRESS OF COUNSEL:

Alabama Department of Corrections
Legal Division
Post Office Box 301501
301 South Ripley Street
Montgomery, AL 36130-1501
(334)353-3889

CERTIFICATE OF SERVICE

I do hereby certify that on the 20th day of July, 2007, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system,

And I hereby certify that I have mailed a copy of the foregoing via United States Mail properly addressed, postage prepaid first class to:

Carl V. Marshall, AIS # 110574
Red Eagle Honor Farm
1290 Red Eagle Road
Montgomery, AL 36110

/s/ Neal P. Conner
NEAL P. CONNER (CONN2024)
ASSISTANT GENERAL COUNSEL

COPY**MEDICAL TRANSPORTATION**FACILITY:
MONTH:

TOTAL MAN-HOURS EXPENDED	0.00
TOTAL ROUND TRIP MILES	0.00

Date	AIS#	Name	Type of Transportation Out Patient Surgery - Dr. Appt	Destination	Round Trip Miles	Total Man- Hours Expende
3-7-07	229770	Ford, Steven	DR	Kilby	43 1/2	2 1/2
"	117998	Griffin, George	DR	"	"	"
"	161565	Rash, Kelly	Lab	"	"	"
"	105567	Short, Richard	ELV	"	"	"
"	110574	Marshall, Carl	DR	"	"	"
3-8-07	168308	Bugard, Duane	MO	"	"	"
3-8-07	142147	Mathis, Duane	GROUP	"	"	"
"	178053	Mathis, Duane	MO	"	"	"
"	178053	Mathis, Duane	MO	"	"	"
3-9-07	229640	Riley, Robbie	DR	"	"	"
"	228537	Gentry, Mckey	DR	"	"	"
"	175922	Rinkow, Roy	"	"	"	"
"	246102	Jones, Luke	"	"	"	"
3-9-07	151414	Morrison, Duane	emergency sick call	Kilby	42 1/2	2 1/2
3-10-07	112858	Hobson, Herman	"	Kelby	42 1/2	2 1/2
3-12-07	151414	Morrison, Duane	DR	"	"	"
"	244333	Williams, Rodgerick	"	"	"	"
"	193413	Adams, Phillip	"	"	"	"
3-13-07	178053	Mathis, Duane	emergency sick call	Kelby	"	"
3-14-07	193413	Adams, Phillip	emergency sick call	Kilby	"	"
3-14-07	132317	Adams, Phillip	emergency sick call	Kilby	"	"
"	161917	Mathis, Duane	"	"	"	"
"	156661	Mathis, Duane	"	"	"	"
"	138239	Mathis, Duane	"	"	"	"

COPY

MEDICAL TRANSPORTATION

FACILITY: _____
 MONTH: _____

TOTAL MAN-HOURS EXPENDED	0.00
TOTAL ROUND TRIP MILES	0.00

Date	AIS#	Name	Type of Transportation Out Patient Surgery - Dr. Appt	Destination	Round Trip Miles	Total Man- Hours Expende d
2-14-07	167565	William, Terry	dental	K16y	45	212
2-14-07	164974	Norman, Bob	"	"	"	"
2-14-07	244520	Brydget, Joseph	"	"	"	"
2-14-07	230024	Chand, Sandi	Eye Clinic	"	"	"
2-14-07	247015	Theresa, Larry	"	"	"	"
2-14-07	201779	Baker, Brian	"	"	"	"
2-14-07	224629	Baker, Lydon	"	"	"	"
2-14-07	126318	Pleedy, Michael	"	"	"	"
2-14-07	229111	Sexton, Brian	"	"	"	"
2-14-07	173188	Infancy, William	"	"	"	"
2-14-07	223431	Orlley, Timothy	"	"	"	"
2-14-07	210253	Ch, Jessie	"	"	"	"
2-14-07	165394	Jakety, Maurice	"	"	"	"
2-14-07	129578	Malden, Anthony	FLV	"	"	"
2-20-07	229111	Sexton, Brian	FLV	"	"	"
2-20-07	223431	Dudley, Timothy	FLV	"	"	"
2-20-07	214647	Colony, Steven	FLV	"	"	"
2-20-07	229720	Ford, Steven	LAR	"	"	"
2-20-07	153526	Edward, Norman	"	"	"	"
2-20-07	110574	Marshall, Carl	"	"	"	"
2-20-07	213372	Davis, James	"	"	"	"
2-20-07	117998	Griffin, Gwend	"	"	"	"
2-21-07	155620	Spinks, Lona	"	"	"	"



PRISON HEALTH SERVICES, INC.

DEPARTMENT OF CORRECTIONS

NOTIFICATION OF NEXT OF KIN

In the event of a serious injury or illness, I request the following person be notified:

LT. OSBORNE RUTLEDGE BROTHER
 MS. DORIS Johnson mother
 Name Relationship

FIELDCREST CT. 281-5669
 284-1059
 Street Address Phone Number

Montgomery, AL ALA.
 City State Zip Code

[Signature] 110574 416-70-3380 04/21/06
 Inmate Signature AIS# SS# Date

Witness Date

INMATE NAME (LAST, FIRST, MIDDLE)	AIS#	D.O.B.	RACE/SEX	FACILITY
Marshall, Carl	110574	8/6/50	B/M	1616g



INTAKE SCREENING

Date:	4/21/06	AIS#: 110574	
Last Name:	Marshall	First:	Carl
Middle:	Vincent		
Birthplace:	Montgomery AL	DOB:	8/6/50
FEMALES: Pregnancy test: (circle one) <u>N/A</u> <u>Positive</u> <u>Negative</u>		B/P: 210/126	Temp: 98.6
		Pulse: 96	Resp: 20
		Weight: 241	FSBS: 179
If level > 200, repeat within 48 hours. Above 300 call M.D.			

Previous Hospitalizations/Surgeries/Major Illness/Current Illness: What? Where?

2 Heart Attacks 2 strokes 98+200 Baptist South

Previous Incarcerations (Date & Facility)

Kilby-97 NIM

Medications:	<input type="checkbox"/> None <u>yes</u>	Special Diet (Prescribed)	<u>Diabetic</u>
Allergies:	<input type="checkbox"/> NKA <u>Adalant, tetracycline, clindamycin</u>	Past Positive TB Skin Test (circle one)	YES - (Complete TB Screening Form) <u>NO</u>

ANY INMATE WHO IS UNCONSCIOUS, SEMICONSCIOUS, ACTIVELY BLEEDING, IN ACUTE PAIN AND URGENTLY IN NEED OF MEDICAL ATTENTION SHOULD IMMEDIATELY BE REFERRED FOR EMERGENCY CARE.

CLINICAL OBSERVATIONS

1) Level of Consciousness: <input checked="" type="checkbox"/> Alert <input checked="" type="checkbox"/> Oriented; time, place, person Describe:	3) Substance Abuse: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Suspected <input type="checkbox"/> Current intoxication/Abuse <input type="checkbox"/> Use <input type="checkbox"/> Withdrawal Symptoms Describe- What kind? Amount/Frequency: • If confirmed Benzo use, then call M.D. If can not be confirmed, call M.D. Last Use: (Time/Date):
2) General Appearance: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal	4b) Affect/Mood: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Manic <input type="checkbox"/> Depressed <input type="checkbox"/> Euphoria <input type="checkbox"/> Flat <input type="checkbox"/> Emotionally Confused Describe:
3) Signs of Trauma: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	4c) Perceptions: <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input checked="" type="checkbox"/> Hearing Voices
4a) Behavior/Conduct: <input checked="" type="checkbox"/> Calm <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Non-Violent <input type="checkbox"/> Agitated <input type="checkbox"/> Uncooperative <input type="checkbox"/> Violent Describe:	5a) Is there h/o actual suicide attempt? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5c) Is there evidence	5b) Does pt describe current suicidal thoughts or ideations? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If ANY of the above in #5 are circled, staff MUST describe here, include previous history and dates:	5d) High risk pt may become assaultive towards staff? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
*Any abnormal observations #4 or 5 require immediate Mental Health Referral.	Triggers for Suicide Watch - Currently Suicidal - History of actual attempt - Fails to maintain control on Close Watch Y or N
	Triggers for Close Watch - Emotionally distraught and unable to regain composure by end of intake process - Actively hallucinating or not making any sense Y or N

6a) Communication Difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6b) Memory Defects: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6c) Hearing Impairment: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6d) Speech Difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7) Physical Aids: <input type="checkbox"/> None <input checked="" type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Dentures <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Braces <input type="checkbox"/> Artificial Limb <input type="checkbox"/> Other	
8) Additional comments, complaints, symptoms: <input checked="" type="checkbox"/> None	
S) <u>Blurred vision</u>	
O) Fever <u>Y</u> <u>N</u> Swollen Glands <u>Y</u> <u>N</u> Signs of Infection <u>Y</u> <u>N</u> Skin Intact <u>Y</u> <u>N</u>	
A) <u>Vitals as above, C x 4, no heart noise noted.</u>	
P) <u>Contact Robbins, MD</u>	

If known Diabetic * Call M.D. for order Initial Insulin given:

I have answered all questions truthfully. I have been told and shown how to obtain medical services. I hereby give my consent for health services to be provided to me by and through PRISON HEALTH SERVICES.

[Signature]
Inmate's Signature/Date

[Signature]
Health Provider Signature/Date

NAME:

AGE:

D.O.B.:

R/S

HEALTH CLASSIFICATIONS:

(Circle One)

1 - No Restrictions

2 - Temporary Restrictions

See Special Needs Form

3 - Permanent Restrictions

See Special Needs Form

4 - A&I (Aged & Infirm)

5 - Not Determined

Recheck _____.

PLACEMENT:

General Population ()

Emergency Department ()

Isolation ()

Medical Observation ()

Other _____

REFERRAL:

CCC Placement ()

Clinic(s) _____

See MD/Mid-Level flow sheet
for clinic(s).

Medical ()

Dental ()

Mental Health ()

Other _____

When: () Immediately

() Next Sick Call

IMMUNIZATIONS ORDERED:

APPRAISAL	N	Abn/Comment
General Movement Deformity Pain, Bleeding Habit, Hygiene	✓	
Neuro Mental Status Intox Withdrawal, Tremor Neuro-Deficits	✓	
Skin Injury, Bruises, Trauma Jaundice Diaphoretic Rash, Lesions, Infestations Needle Marks Color, Turgor	✓	Tattoos - d B200 no p
Head Normocaphalic Atraumatic Hair, Scalp	✓	
Eyes Glasses/Vision Pupils Sclera, Conjunctiva	✓	
Ears Appearance Canals, TMs, Hearing	✓	
Nose Epistaxis Sinuses	✓	
Throat Teeth, Gums, Dentures Mouth, Tongue, Tonsils Airway	✓	
Neck C-Spine, Mobility Veins, Carotids Thyroid, Lymph Nodes	✓	
Chest Config. Ausc/Resp Cough/Sputum Breast/Masses	✓	
Heart Ausc Rate, Rhythm Murmurs, Ectopy	✓	
Abdomen Bowel Sounds Palp, G/R/T, Hernia	✓	
GU Flank Tenderness Bladder Tenderness/Distention	✓	
Back ROM, Spasm, Injury	✓	
Extremities Edema, Pulse	✓	
Genitals Injuries/Lesions		deferred
Pelvic Pap		
Rectal/Guac (required @ 45 and up) Deferred/follow-up:		

Medications Ordered: _____

M.D. or Mid-Level Signature

Date/Time

INTAKE HEALTH EVALUATION

NAME: Marshall, Carl
 AIS #: 112574
 D.O.B.: 8-6-50

R.N. evaluation within 24 hours.

Age: 54 Sex: M Race: B Height: 6'2" Weight: 240

Temp: 98.6 B/P: 180/100 Pulse: 68 Resp: 20

** B/P - If greater than 140/90, repeat in 1 hour. Refer to Mid-Level if B/P remains up.

Do you now or have you ever had, or been treated for:

7885-154

Problem	Y	N	Problem	Y	N	Problem	Y	N
Head Trauma		✓	Gastritis <u>Hernia</u>		✓	HIV/AIDS ***		✓
Loss of Consciousness		✓	Ulcers		✓	***Medications Verified		
Severe Headaches		✓	Bleeding		✓	Hepatitis - Type		✓
Vertigo/Dizziness		✓	Gall Bladder/Pancreas		✓	Gonorrhea		✓
Vision Problems	✓		Liver Problems		✓	Syphilis		✓
Hearing Problems		✓	Arthritis		✓	Lice, Crabs, Scabies		✓
Seizures		✓	Joint Muscle Problem		✓			
Strokes	✓		Back/Neck Problem		✓	LMP		
Nervous Disorders		✓	Kidney Stones/Dz		✓	Date		
DT's		✓	Bladder/Kidney Infection		✓	Duration		
Heart Condition	✓		Alcoholism		✓	Normal		
Angina/Heart Attack	✓		Drug Abuse		✓	Regularity		
High Blood Pressure	✓		Psychiatric History		✓	Gravida/Para		
Anemia/Blood Disorder		✓	Suicidal Thoughts**		✓	AB/Miscarriage		
Sickle Cell or Trait		✓	**Immediate M.H. Referral			Contraception		
Lung Condition		✓	T.B.			Type:		
Asthma *		✓	PPD - date given: <u>4/24/06</u>					
*Peak Flow Reading			RFA/LFA			Lab Tests - Dates	N	Ab
Bronchitis		✓	Date read: <u>4/24/06</u>			Diagnostic Profile II		
Emphysema		✓	Results: <u>0</u> mm			RPR		
Pneumonia		✓	Visual Acuity			Urine Dip Stick		
Diabetes	✓		OD OS					
Hay Fever/Allergies		✓	OU <u>20/20</u> RX			EKG (@ age 35)		

Immunization History: _____

***HIV Medications: _____

Acute or Chronic Problem Noted: (Y) N

Refer to Mid-Level or M.D. if yes.

[Signature]
 RN or Mid-Level, Signature

4/25/06
 Date/Time

[illegible]

DAY SHIFT color ink -	EVENING SHIFT color ink -	NIGHT SHIFT color ink -
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[illegible]

INITIALS	NURSE'S SIGNATURE	INITIALS	NURSE'S SIGNATURE	INITIALS	NURSE'S SIGNATURE
RB ef	(K. Brunette) E. Johnson (RN)	mo	✓		

INSTRUCTIONS:		INJECTION SITE CODES:			
INITIAL APPROPRIATE BOX WHEN MEDICATION OR TREATMENT IS GIVEN.		1. RIGHT DORSAL GLUTEUS	5. RIGHT LATERAL THIGH	9. RIGHT UPPER ARM	13. UPPER BACK LEFT
INITIAL E INITIALS WHEN MEDICATION OR TREATMENT IS REFUSED.		2. LEFT DORSAL GLUTEUS	6. LEFT LATERAL THIGH	10. LEFT UPPER ARM	14. UPPER BACK RIGHT
INITIAL APPROPRIATE BOX WHEN MEDICATION OR TREATMENT IS REFUSED.		3. RIGHT VENTRAL GLUTEUS	7. RIGHT DELTOID	11. RIGHT ANTERIOR THIGH	15. UPPER CHEST LEFT
INITIAL REASON FOR REFUSAL. UNDER MEDICATION CODE.		4. LEFT VENTRAL GLUTEUS	8. LEFT DELTOID	12. LEFT ANTERIOR THIGH	16. UPPER CHEST RIGHT
					17. TO RIGHT AND ABOVE LEVEL OF UMBILICUS
					18. TO LEFT AND ABOVE LEVEL OF UMBILICUS
					19. TO RIGHT AND BELOW LEVEL OF UMBILICUS
					20. TO LEFT AND BELOW LEVEL OF UMBILICUS



SPECIAL NEEDS COMMUNICATION FORM

Date: 5/8/06

To: DOC

From: OPC

Inmate Name: Marshall, Carl ID#: 110574

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Report TO OPC on 5/15/06 +
5/22/06 AT 7:00AM for injection
MEDICAL Hold until 5/23/06

Date: 5/8/06 MD Signature: UU B. Adams CNP/ Time: _____
Graves, W



FINGER STICK BLOOD RECORD FORM

NAME: Earl Marshall INSTITUTION/FACILITY: _____ I.D. # 110278 D.O.B.: 8/6/50

CELL SITE: _____

PHYSICIAN ORDER/INSTRUCTIONS: _____

DATE	TIME	INITIALS	BLOOD SUGAR RESULTS	URINARY KETONE LEVEL (if required)	INITIALS	*	ACTIONS TAKEN/COMMENTS
4/21	1500	6K	610				Recheck - 169 - after dinner
4/22	0400	6K	610				
4/22	1500	6K	610				
4/23	1500	6K	610				Recheck - 410 after dinner
4/24	0400	6K	610				
4/24	1500	6K	52				
4/25	0400	6K	610				Recheck - 410 after dinner
4/26	0400	6K	98				Recheck - 410 after dinner
4/27	0400	6K	57	5/4/06			
4/27/06	1500	6K	56	6/8			
4/28	0400	6K	68				
4/28	1500	6K	609				
4/29	0400	6K	68				
4/30	1500	6K	68				Recheck - 269 @ 1545 after dinner
5/1	1500	6K	68				
5/2	0400	6K	178				
5/3	0410	6K	219				
5/4	0400	6K	296				

*Check if results called to physician.

Date	Initials	Signatures

Date	Initials	Signatures



SPECIAL NEEDS COMMUNICATION FORM

Date: 4/21/06To: ADDCFrom: WxInmate Name: Marshall, CARL ID#: 110514

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Add 22 Sat, 23 Sun, 24 MonBlood Pressure ✓ for 4 wks 8 times
a week Tues + Thurs - On w/w @ 0500Blood Sugar ✓ x 3 deep, on w/w @
0300Date: 4/21/06 MD Signature: V/D DeRobbins / D. Blunsen Time: _____

RECEIVING SCREENING FORM

INMATE'S NAME: Marshall, Carl DATE: 4/21/06 TIME: 7:00AMDOB: 8-6-50 OFFICER: COT Hives INSTITUTION: KILBY

RECEIVING OFFICER'S VISUAL OPINION

	YES	NO
Is the inmate conscious?	<u>✓</u>	<u> </u>
Does the inmate have any obvious pain or bleeding or other symptoms suggesting the need for doctor's care?	<u> </u>	<u> </u>
Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care?	<u> </u>	<u> </u>
Any obvious fever, jaundice, or other evidence of infection which might spread through the institution?	<u> </u>	<u> </u>
Is the skin in poor condition or show signs of vermin or rashes?	<u> </u>	<u> </u>
Does the inmate appear to be under the influence of alcohol, or drugs?	<u> </u>	<u> </u>
Are there any signs of alcohol or drug withdrawal? (Extreme perspiration, shakes, nausea, pinpoint pupils, etc.)	<u> </u>	<u> </u>
Is the inmate making any verbal threats to staff or other inmates?	<u> </u>	<u> </u>
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?	<u> </u>	<u> </u>
Does the inmate have any obvious physical handicaps?	<u> </u>	<u> </u>

FOR THE OFFICER

Was the new inmate oriented on sick/dental call procedures?

This inmate was a. Released for normal processing

 b. Referred to health care unit

 c. Immediately sent to the health care unit.

COT Hives

Officer's Signature

This form will be completed at receiving and will be filed in the inmate's medical jacket to comply with NCCH Standards.

DIABETES CLINIC

Q 3-months

Name: Marshall, Card DOB: 5-6-48 AISH: 110574 R/S: BM

PATIENT HISTORY

1) HTN
2) DM II
Diagnosis: Type 1 ☐ Type 2 ☒ Date of Diagnosis: 4-21-06
 Current Meds: Glucoral 10mg QD, Calan SR 240mg QD, Lisinopril 20mg QD
 Diet/Exercise: NO / Occ. Compliant: Y ☒ N ☐
 Frequency of BG monitoring: once daily
 Risk factors (check all that apply)
 Family History: Smoker HTN Obesity CAD Hyperlipidemia Renal Disease Tobacco use
T. 92.9 S. 97.7 B. 165

VARIABLE	Date	7-10-7	1350	Date	Date
BP/Weight/Pulse	<u>140/100</u>	<u>250</u>	<u>81</u>		
CP/dizziness/Indigestion	<u>0/0/0</u>				
Exertional Dyspnea	<u>0</u>				
Urinary frequency	<u>0</u>				
Fundi exam (annually)	<u>out 7/10/07</u>				
Dental exam (annually)	<u>out 7/10/07</u>				
Hand and Foot pain	<u>0/0</u>				
General Appearance	<u>NAD, W, NN</u>				
Heart	<u>S1 S2 normal</u>				
JVD/Carotid Bruits	<u>scd 045</u>				
Periph. Pulses/edema	<u>+2 PP, P, T, D</u>				
Microfilament (annually)	<u>Secable 7/10/07</u>				

LABS	Date	Date	Date
Fasting Diagnostic Profile II (base line)	<u>2/21/07</u>	<u>creat 1.1</u>	
Hgb A1c q 3-6 mos	<u>2/21/07</u>	<u>TC 186 HDL 36</u>	
BMP (per MD/NP)	<u>2/21/07</u>	<u>Trig 213 LDL 108</u>	
UA Dipstick	<u>2/21/07</u>	<u>9.4%</u>	
Microalb (annually)	<u>4/28/06</u>	<u>out 7/10/07</u>	
EKG (base line)	<u>4/28/06</u>	<u>S1, LVI, Mobitz II</u>	
Disease Control	Good/Fair/Poor	Good/Fair/Poor	Good/Fair/Poor
	Improved/Worsened	Improved/Worsened	Improved/Worsened

PLAN

Flu vac (annually)	<u>2006</u>		
Pneumovax	<u>out 7/10/07</u>		
Patient Edu/Training	<u>DM II, HTN</u>		
Completed Master Problem Sheet	<u>yes</u>		
Next F/U	<u>2 wks Flu shot</u>		
Signature	<u>[Signature]</u>		

SHORT TERM GOALS

LONG TERM GOALS

- 1 Rev DM II lipid control, HbA1c
- 2 Rev Urine microalbumin
- 3 FBG's BID x 2 wks
- 4 cont. Check, Calan

- 1 pt CAD
- 2 HbA1c ~ 5.5 to 6.0
- 3 LDL goal < 100 Trig < 150
- 4 RD - 12 hr



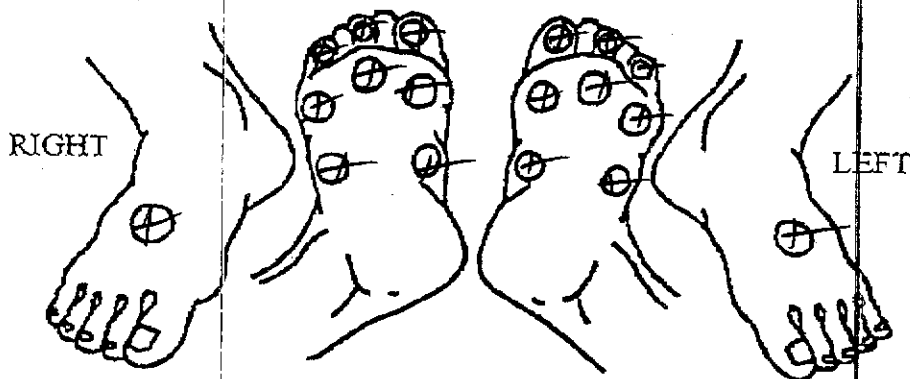
PRISON
HEALTH
SERVICES
INCORPORATED

MONOFILAMENT TESTING FOR DIABETICS

Fill in the following blanks with a "Y" or "N" to indicate findings

	RIGHT	LEFT
Is there a foot ulcer now?	N	N
Is there a history of foot ulcer?	N	N
Is there an abnormal shape of the foot?	N	N
Is there a toe deformity?	N	N
Are the toenails thick or ingrown?	Y	Y
Is there callus buildup?	N	N
Is there swelling?	N	N
Is there elevated skin temperature?	N	N
Is there muscle weakness?	N	N
Can the inmate see the bottom of feet?	Y	Y
Is the inmate wearing improperly fitting shoes?	N	N
Does the inmate use footwear appropriate?	Y	Y
Pulses? DP/PT	+2 DP/PT	+2 DP/PT

Note the level of sensation in the circles: (+) → Can feel the 5.07 filament (-) → Can't feel the 5.07 filament



Skin Conditions on the Foot or Between the Toes:

Draw in: Callous , Pre-ulcer , Ulcer  (note length and width in cm)
Label with: R - Redness, M - Maceration, D - Dryness, T - Tinea

Risk Category:

- ☒ 0 No loss of protective sensation.
☐ 1 Loss of protective sensation
☐ 2 Loss of protective sensation with either high pressure (callous/deformity), or poor circulation.
☐ 3 History of plantar ulceration, neuropathic fracture (Charcot foot) or amputation.

Education done about DM foot care Education Received by pt

Name <u>Marshall, Carl</u>	AIS NO <u>110574</u>	Date <u>7/6/07</u>	By <u>M. Cray</u>
-------------------------------	-------------------------	-----------------------	----------------------

INMATE NAME Marshall, Carl AIS # 110574

[illegible]

PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

Date: 3/7/07 Time: _____ Facility: Kilby Correctional FacilityCheck all applicable CIC's being evaluated: Card/HTN DM GI ID PUL SZ TBSUBJECTIVE:OBJECTIVE: BP 180/110 HR 50 RR 18 Temp 99 Wt 247 Peak Flow _____

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ

Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds,

Cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT,

Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

- 1) DM
- 2) HTN

No. 4a.
 Amalasee questionable
 labs 2/07 ok. Cholesterol 200, A, C 9.4.
 (+) smoking → decreased
 lungs clear. Heart MMR 5 @.
 Edema, hives.

Glucotrol 5mg p.o. QD
 Calan SR 180mg p.o. QD
 Lisinopril 20mg p.o. BID
 EC ASA 325mg p.o. QD

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
 Status: I=Improved, S=Stable, W=Worsened

DM	HTN/CARD	SZ	PUL	ID	GI	OTHER
Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control
G (F) P	G (F) P	G F P	G F P	G F P	G F P	G F P
Status	Status	Status	Status	Status	Status	Status
I (S) W	I (S) W	I S W	I S W	I S W	I S W	I S W

PLAN:

- 1) ↑ Calan
- 2) ↑ Glucotrol

2) ✓ A, C next visit.

F/U: Routine 90 days: ✓ Other _____

Problem List Updated: Yes No

Physician/NP/PA

Marshall Carl
 NAME

male
 GENDER

(B) / W
 RACE

110574
 AIS#
8/6/50
 DOB

DEPARTMENT OF CORRECTIONS
NURSE'S
CV/HTN CHRONIC CARE CLINIC

S: CHRONIC CARE CLINIC			ALLERGIES	
DATE/TIME	3/7/07	@ 0850	The tracymedine, Clonidine	
O: VS	T 99	P 90	R 16	WT 247
BP	180/110	IF BP > 140/90 REFER TO MD/NP/PA		
Do you smoke?	<input checked="" type="radio"/> Y	<input type="radio"/> N	Date:	
Use salt?	<input type="radio"/> Y	<input checked="" type="radio"/> N	HX a treadmill? <input type="radio"/> Y <input checked="" type="radio"/> N	
Family History of CVHTN?	<input type="radio"/> Y	<input checked="" type="radio"/> N	Date:	
Obese?	<input type="radio"/> Y	<input checked="" type="radio"/> N		
Stress?	<input type="radio"/> Y	<input checked="" type="radio"/> N		
Blurred vision	<input type="radio"/> Y	<input checked="" type="radio"/> N		
Headache	<input type="radio"/> Y	<input checked="" type="radio"/> N		
Fatigue	<input type="radio"/> Y	<input checked="" type="radio"/> N		
Muscle weakness	<input type="radio"/> Y	<input checked="" type="radio"/> N		
Polyuria	<input type="radio"/> Y	<input checked="" type="radio"/> N		
Epistaxis	<input type="radio"/> Y	<input checked="" type="radio"/> N		
S.O.B.	<input type="radio"/> Y	<input checked="" type="radio"/> N	P: LABS REVIEWED	
Compliant with meds	<input type="radio"/> Y	<input checked="" type="radio"/> N	Labs ordered	
KOP	<input type="radio"/> Y	<input checked="" type="radio"/> N	Last CMP-14 2/28/07	
Counseled on risk factors	<input type="radio"/> Y	<input checked="" type="radio"/> N	Last EKG 4/28/04	
Describe: <u>Non-Modifiable</u>				
① Race ② Age ③ Gender ④ Heredity				
<u>Modifiable</u> ① Smoking cessation ② Diet ③ Activity ④ Weight reduction				
Labs/EKG WNL	<input type="radio"/> Y	<input checked="" type="radio"/> N		
CXR if over 50	<input type="radio"/> Y	<input checked="" type="radio"/> N		
Education Done	<input type="radio"/> Y	<input checked="" type="radio"/> N		
S.O.B. / Dizziness, blurred vision	<input type="radio"/> Y	<input checked="" type="radio"/> N		
Severe HA, if possible take	<input type="radio"/> Y	<input checked="" type="radio"/> N		
Weakness, numbness	<input type="radio"/> Y	<input checked="" type="radio"/> N		
Topic: <u>S/S of stroke</u> VS. <u>heart attack</u> (1 side)	<input type="radio"/> Y	<input checked="" type="radio"/> N		
Recently admitted to hospital/infirmar	<input type="radio"/> Y	<input checked="" type="radio"/> N	CURRENT MEDICATIONS:	
Notes: 4 BP reading addressed			Glax SR 180 mg po. QD	
continue to HTN teaching & Plan			Lisinopril 20 mg po. BID	
Encourage compliance & med			EC ASA 325 mg po. QD	
diet + exercise to ↓ risk of stroke				
heart attack + blindness.				
			Status: (circle) 180/120	
			IMPROVED UNCHANGED WORSENER	
			Level of Control: (circle)	
			GOOD FAIR POOR	
			CCC WITH NURSE (circle)	
			1, 2, 3 Months	
			CCC WITH MD (circle)	
			1, 2, 3, 4, 5, 6 Months	
INMATE NAME	NUMBER	AGE	RACE/SEX	SIGNATURE
Marshall, Carl	110574	54	B/M	<i>[Signature]</i>
Control Good---BP < 140/90		Status: Improved---BP < previous visit		
Fair----BP 140-160/90/100		Unchanged---BP unchanged		
Poor----BP > 160/100		Worsened----BP increased,		

NURSE'S DIABETIC CHRONIC CARE CLINICS

S: DAY CHRONIC CARE CLINIC				ALLERGIES
DATE/TIME: 7/1/07 @ 0855				Intracrine, Clonidine
O: VS T 99 P 80 R 18				
BP 180/110 WT 247				TYPE I TYPE II
Any reactions:		Y	N	
Thirst, vomiting, or abdominal pain		Y	N	
Skin or foot problems:		Y	N	
Foot exam done:		Y	N	
Rotation of injection sites	N/A	Y	N	
Changes in eyes		Y	N	
Dietary compliance:		Y	N	P: LABS
Noncompliant---Education done		Y	N	
Medication compliant		Y	N	Last HgbA1C:
Noncompliant---Education done		Y	N	Date 2/20/07 Result 9.4
Tremors		Y	N	
Reviewed canteen list	KEHF	Y	N	
Compliant		Y	N	
If noncompliant, education done		Y	N	
Infirmity or hospital since last CCC visit		Y	N	ORDERS:
If yes, date		Y	N	
Review of FLU vaccine		Y	N	
Review of Pneumovax		Y	N	
Fundoscopy exam	Referral 4/25/06	Y	N	
Annual Diabetic Checklist updated		Y	N	
NOTES:				MEDICATION:
In 3 mo HbA1c level was ↓ to 8.5				Glucotrol 5mg
87% & in note will continue to				P.O. QD
be complete med & diet &				
EXERCISE				
				Status: (circle) 7.8
				Improved, Unchanged, Worsened
				Control: (circle)
				Good, Fair, Poor
				CCC NURSE (circle)
				EVERY 1, 2, 3 months
				CCC WITH MD (circle)
				1, 2, 3, 5, 6 months
Education done: 1. SOULS & P 2. INSIDE made straight along EXERCISE & circulation Topic: FOOT CARE		IMPROVED FOOT For signs of foot prob. Report: Tingling - Pain - infected corns - COLEMAN - WICKES, SORES		
INMATE NAME	NUMBER	AGE	RACE/SEX	SIGNATURE
Marshall, Carl	110574	56	B/M	[Signature]

Control Good HgbA1C WNI
Fair HgbA1C within 2% of normal
Poor HgbA1C 2% above normal

Status Improved--Decrease in HgbA1C and weight recovered by 5%
Unchanged--No change in HgbA1C and weight
Worsened--Increase in HgbA1C and weight

PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

REHT

Date: 12/11/06 Time: _____ Facility: Kilby Correctional FacilityCheck all applicable CIC's being evaluated: Card/HTN DM GI ID PUL SZ TBSUBJECTIVE:OBJECTIVE: BP 180/120 HR 84 RR 18 Temp 98 Wt 247 Peak Flow _____

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ

Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT, Cardiopulmonary A/P ratio; SZ-HEENT, neurological; GI-abdomen.

- 1) HTN
2) DM

no ch. glucose 150
not taking BP meds bid (dinning)
No recent labs.
lungs few @ rhonchi. Heart
RAA 5 @. 0 edema, bruits

Glucotrol 5 mg p.o. QD
Lan SR 180 mg p.o. QD
Lisinopril 20 mg p.o. BID
EC ASA 325 mg p.o. QD

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
Status: I=Improved, S=Stable, W=Worsened

DM	HTN/CARD	SZ	PUL	ID	GI	OTHER
Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control
G F P	G F P	G F P	G F P	G F P	G F P	G F P
Status	Status	Status	Status	Status	Status	Status
I S W	I S W	I S W	I S W	I S W	I S W	I S W

PLAN: 1) Compliance
2) Check labs next visit.

F/U: Routine 90 days: ✓ Other _____

Problem List Updated: Yes No

Roll

Physician/NP/PA

Marshall, Carl

NAME

110574

AIS#

male

GENDER

(B) W

RACE

8-6-50

DOB

DEPARTMENT OF CORRECTIONS

NURSE'S

DIABETIC CHRONIC CARE CLINICS

S: DAY CHRONIC CARE CLINIC				ALLERGIES Tetoraxylone Clonidine	
DATE/TIME: 12/11/06 @ 0830					
O: VS T 98 P 84 R 18					
BP 100/100 WT 247.50 lbs				TYPE I <u>TYPE II</u>	
Any reactions:		Y	<input checked="" type="radio"/>		
Thirst, vomiting, or abdominal pain		Y	<input checked="" type="radio"/>		
Skin or foot problems:		Y	<input checked="" type="radio"/>		
Foot exam done:		<input checked="" type="radio"/>	N		
Rotation of injection sites (N/A)		Y	N		
Changes in eyes		Y	<input checked="" type="radio"/>		
Dietary compliance:		<input checked="" type="radio"/>	N	P: LABS	
Noncompliant---Education done		Y	N		
Medication compliant		<input checked="" type="radio"/>	N	Last HgbA1C:	
Noncompliant---Education done		Y	N	Date 4/24/06 Result 7.8%	
Tremors		Y	<input checked="" type="radio"/>		
Reviewed canteen list		Y	N		
Compliant		Y	N		
If noncompliant, education done		Y	N		
Infirmary or hospital since last CCC visit		Y	<input checked="" type="radio"/>	ORDERS:	
If yes, date					
Review of FLU vaccine 11/2/06		<input checked="" type="radio"/>	N		
Review of Pneumovax		<input checked="" type="radio"/>	N		
Fundoscopic exam Eye normal 4/25/06		<input checked="" type="radio"/>	N		
Annual Diabetic Checklist updated		<input checked="" type="radio"/>	N		
NOTES:		MEDICATION:			
educ. material given		Glucotrol 5gpo QD			
In 3 mos A1C level will be		EC ASA 325gpo QD			
L770 + in note will continue					
to be compliant & diet, med					
& Exercise					
		Status: (circle) Improved, Unchanged, Worsened			
		Control: (circle) Good, Fair, Poor			
		CCC NURSE (circle) EVERY 1, 2, 6 months			
		CCC WITH MD (circle) 1, 2, 4, 5, 6 months			
Education done <u>Δ SOCKS & P</u> <u>EXERCISE</u> made straight aegs Topic <u>Foot Care</u>		IMPROVED Feet For signs of Foot Prob. Report: Tingling - Itch - infected corns - color changes - ulcers, sores			
INMATE NAME		NUMBER		AGE	
Marshall, Carl		110574		56	
		RACE/SEX		SIGNATURE	
		B/M			

Control Good HgbA1C WNI
Fair---HgbA1C within 2% of normal
Poor---HgbA1C > 2% above normal

Status Improved---Decrease in HgbA1C and weight decrease by 5%
Unchanged---No change in HgbA1C and weight
Worsened---Increase in HgbA1C and weight

CV/HTN CHRONIC CARE CLINIC

S: CHRONIC CARE CLINIC			ALLERGIES		
DATE/TIME 12/11/07 @ 0830			Tetrazolone Chlorzoxazone		
O: VS T 99 P 84 R 18 WT 247.50 lbs			HX a treadmill? Y (N)		
BP 180/120 IF BP > 140/90 REFER TO MD/NP/PA			Date:		
Do you smoke?			HX bypass surgery: Y (N)		
Use salt?			Date:		
Family History of CVHTN? Entire family					
Obese?					
Stress?					
Blurred vision					
Headache					
Fatigue					
Muscle weakness					
Polyuria					
Epistaxis					
S.O.B.					
Compliant with meds KOP			P: LABS REVIEWED		
Counseled on risk factors			Labs ordered		
Describe: Non-modifiable			Last CMP-14 4/26/07		
Race - Af. Am			Last EKG 4/28/07		
Age - 47 years					
Gender - male					
Labs/EKG WNL					
CXR if over 50					
Education Done					
Topic: Stroke					
Recently admitted to hospital/infirmery					
Notes:			CURRENT MEDICATIONS:		
Educ. material given			Calcium SR 180 mg p.o. BID		
MD discussed med. on compliance			Lisinopril 20 mg p.o. BID		
In 3 mos. BP reading will be					
@ least 140/90 + in med					
will be compliant to med. diet					
+ Exercise					
			Status: (circle) IMPROVED UNCHANGED WORSENERD		
			Level of Control: (circle) GOOD FAIR POOR		
			CCC WITH NURSE (circle) 1, 2, 3 months		
			CCC WITH MD (circle) 1, 2, 3, 4, 5, 6 Months		
INMATE NAME		NUMBER	AGE	RACE/SEX	SIGNATURE
Marshall, Carl		110574	50	B/A	

Control Good---BP < 140/90
Fair----BP 140-160/90/100
Poor----BP > 160/100

Status: Improved---BP < previous visit
Unchanged---BP unchanged
Worsened---BP increased



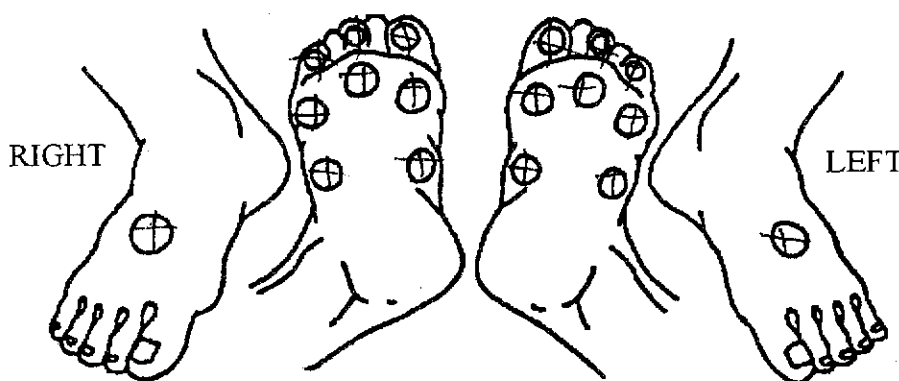
PRISON
HEALTH
SERVICES
INCORPORATED

MONOFILAMENT TESTING FOR DIABETICS

Fill in the following blanks with a "Y" or "N" to indicate findings

	RIGHT	LEFT
Is there a foot ulcer now?	n	n
Is there a history of foot ulcer?	n	n
Is there an abnormal shape of the foot?	n	n
Is there a toe deformity?	n	n
Are the toenails thick or ingrown?	n	n
Is there callus buildup?	n	n
Is there swelling?	n	n
Is there elevated skin temperature?	n	n
Is there muscle weakness?	n	n
Can the inmate see the bottom of feet?	Y	Y
Is the inmate wearing improperly fitting shoes?	Y	Y
Does the inmate use footwear appropriate?	Y	Y
Pulses? DP/PT	+2	+2

Note the level of sensation in the circles: (+) → Can feel the 5.07 filament (-) → Can't feel the 5.07 filament



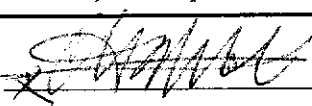
Skin Conditions on the Foot or Between the Toes:

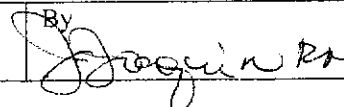
Draw in: Callous , Pre-ulcer , Ulcer  (note length and width in cm)
Label with: **R** - Redness, **M** - Maceration, **D** - Dryness, **T** - Tinea

Risk Category:

- ☒ 0 No loss of protective sensation.
☐ 1 Loss of protective sensation
☐ 2 Loss of protective sensation with either high pressure (callous/deformity), or poor circulation.
☐ 3 History of plantar ulceration, neuropathic fracture (Charcot foot) or amputation.

Education done about Foot Care

Education Received 

Name <u>Marshall, Carl</u>	AIS NO <u>110574</u>	Date <u>12/11/06</u>	By <u></u>
-------------------------------	-------------------------	-------------------------	--

MARSHALL, CARL V. 110574 B/M 5/04/2006 3:37PM TRANS NR 88093

LI	ITEM NBR	ISSUE QTY	DESCRIPTION	UI	UNIT COST	EXTENDED COST
1	909	1	JUMBO CHILI CHSE DOG	EA	\$2.18	\$2.18
2	953	1	HORMEL M/W CHILI	EA	\$1.28	\$1.28
3	904	1	ICE CREAM	EA	\$1.30	\$1.30
4	904	1	ICE CREAM	EA	\$1.30	\$1.30
**** LAST ITEM ****						=====
TOTAL PURCHASES						\$6.06

OLD PMOD BALANCE 6.99 TOTAL PURCHASE 6.06 NEW PMOD BALANCE .9
TOTAL APPLIED TO WEEKLY LIMIT 12.01 POSTED BY: INMATE WORKERS

I CERTIFY THAT I RECEIVED ALL ITEMS AND QUANTITIES LISTED ABOVE.

SIGNATURE

DATE

BED NBR: M 086B

BSV BIDx30cd

*Check if results called to physician.

Date	Initials	Signatures

KILBY CORRECTIONAL FACILITY
C A I T E E N S A L E S R E C E I P T

MARSHALL, CARL V. 110574 B/M 5/02/2006 3:35PM TRANS NR 87273

LI	ITEM NBR	ISSUE QTY	DESCRIPTION	UI	UNIT COST	EXTENDED COST
1	962	1	DR. PEPPER	EA	\$.52	\$.52
2	960	1	COKE	EA	\$.52	\$.52
3	924	2	MICROWAVE POPCORN	EA	\$.50	\$1.00
**** LAST ITEM ****						=====
TOTAL PURCHASES						\$2.04

OLD PMOD BALANCE 54.55 TOTAL PURCHASE 2.04 NEW PMOD BALANCE 52.51
TOTAL APPLIED TO WEEKLY LIMIT .00 POSTED BY: INMATE WORKERS

I CERTIFY THAT I RECEIVED ALL ITEMS AND QUANTITIES LISTED ABOVE.


SIGNATURE

DATE


BED NBR: M 0868

MARSHALL, CARL V. 110574 B/M 5/02/2006 9:57AM TRANS NR 86956

LI	ITEM NBR	ISSUE QTY	DESCRIPTION	UI	UNIT COST	EXTENDED COST
1	960	2	COKE	EA	\$.52	\$1.04
2	912	1	DOUBLE CHEESE BURGER	EA	\$1.73	\$1.73
**** LAST ITEM ****						
TOTAL PURCHASES						\$2.77

OLD PMOD BALANCE 57.32 TOTAL PURCHASE 2.77 NEW PMOD BALANCE 54.55
 TOTAL APPLIED TO WEEKLY LIMIT .00 POSTED BY: INMATE WORKERS

I CERTIFY THAT I RECEIVED ALL ITEMS AND QUANTITIES LISTED ABOVE.


 SIGNATURE

DATE

BED NBR: M 086B

C A N T E E N S A L E S R E C E I P T

MARSHALL, CARL V. 110574 B/M 5/03/2006 9:13AM TRANS NR 87476

LI	ITEM NBR	ISSUE QTY	DESCRIPTION	UI	UNIT COST	EXTENDED COST
1	140	1	REESE CUPS	EA	\$.57	\$.57
2	141	1	SNICKERS	EA	\$.57	\$.57
3	173	3	G/F CORN CHIPS	EA	\$.48	\$1.44
4	174	3	G/F CHEESE CURLS	EA	\$.42	\$1.26
5	183	1	TROPHY MIXED NUTS	EA	\$1.05	\$1.05

***** LAST ITEM *****

=====

TOTAL PURCHASES \$4.89

OLD PMOD BALANCE 13.44 TOTAL PURCHASE 4.89 NEW PMOD BALANCE 8.55

TOTAL APPLIED TO WEEKLY LIMIT 12.01 POSTED BY: PATTI P VERMILYER

I CERTIFY THAT I RECEIVED ALL ITEMS AND QUANTITIES LISTED ABOVE.

SIGNATURE

DATE

BED NBR: M 0868

Facility Name:	Month/Year of Charting	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Glucotrol 5mg P.O. BID X 180 days	12/06	A 3/7/07																															
		Start Date: 12/11/06															Prescriber: Dr. Paffine																
		Stop Date: 6/11/07															RX #:																
Calan SR 180mg P.O. BID X 180 days	12/06	A 3/7/07																															
		Start Date: 12/11/06															Prescriber: Dr. Paffine																
		Stop Date: 6/11/07															RX #:																
Lisinopril 20mg P.O. BID X 180 days	12/06																																
		Start Date: 12/11/06															Prescriber: Dr. Paffine																
		Stop Date: 6/11/07															RX #:																
EC ASA 325mg P.O. BID X 180 days	12/06																																
		Start Date: 12/11/06															Prescriber: Dr. Paffine																
		Stop Date: 6/11/07															RX #:																
		Start Date:															Prescriber:																
		Stop Date:															RX #:																
		Start Date:															Prescriber:																
		Stop Date:															RX #:																

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
Allergies					1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication held 9. No Show 10. Other
TEN, Clonidine					
Housing Unit:					
Patient ID Number:					
Patient Name:					
Marshall, Carl					

Facility Name:	Month/Year of Charting: 7/07																														
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
4 Glucotrol 10mg P.O. QD X180 days																															
Start Date: 8/7/07	Prescriber: Dr. Robbins																														
Stop Date: 9/3/07	RX #:																														
Calan SR 240mg P.O. QD X180 days																															
Start Date: 12/7/07	Prescriber: Dr. Robbins																														
Stop Date: 6/11/07	RX #:																														
Lisinopril 20mg P.O. BID X180 days																															
Start Date: 12/7/07	Prescriber: Dr. Robbins																														
Stop Date: 6/11/07	RX #:																														
EC ASA 325mg P.O. QD X180 days																															
Start Date: 12/7/07	Prescriber: Dr. Robbins																														
Stop Date: 6/11/07	RX #:																														
Start Date:	Prescriber:																														
Stop Date:	RX #:																														
Start Date:	Prescriber:																														
Stop Date:	RX #:																														

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
Allergies					1. Discontinued Order
Hydroxyzine, Clonidine					2. Refused
Housing Unit:					3. Patient out of facility
Patient ID Number:					4. Charted in Error
Patient Name:					5. Lock Down
Marshall, Carol					6. Self Administered
					7. Medication out of Stock
					8. Medication Held
					9. No Show
					10. Other

Date of birth: 8/6/50



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Carl Marshall Date of Request: MAY 1, 2006
ID # 110574 Date of Birth: 8/6/50 Location: M-86
Nature of problem or request:

BLOOD SUGAR HAS JUMPED
TO HIGH FROM 44 - 296 IN LESS
THAN 2 WKS

[Signature]
Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
Time: AM PM
Allergies:

<p>RECEIVED</p> <p>Date: _____</p> <p>Time: _____</p> <p>Receiving Nurse Initials _____</p>

(S)ubjective:

Su Net

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

5/1/06
60

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

General Sick Call

Facility: <u>KCF</u>	
Patient Name: <u>Marshall</u>	<u>Carl</u>
Inmate Number: <u>110 574</u>	
Date of Report: <u>5-24-06</u>	First Date of Birth: <u>8-14-50</u>
	MM DO YYYY
	Time Seen: <u>0640</u> AM/PM Circle One

Subjective: Chief Complaint(s): BS has been going ↑ too high

Onset: _____

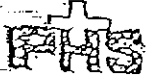
Brief History: S3 40 Bm e HR NIDDM, HTN
(Continue on back if necessary)Objective: Vital Signs: (As Indicated) T: 98.6 P: 79 RR: 24 B/P: 199/105 Wgt 243.5
Examination Findings: FSBS @ 7:15A 301
(Continue on back if necessary)Assessment: (Referral Status) Preliminary Determination(s): alt. in comfort R/T
☒ Referral NOT REQUIRED alone statement
☒ Referral REQUIRED due to the following: (Check all that apply)
☐ Recurrent Complaint (more than 2 visits for the same complaint)
☒ Other: Uncontrolled BS

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

- ☐ Instructions to return if condition worsens.
☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (if NO then schedule patient for appropriate follow-up visits)
☐ Other: _____

OTC Medications given ☒ NO ☐ YES (If Yes List): _____Referral: ☐ NO ☒ YES (If Yes, Whom/Where): B Adams CAMPReferral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): _____Date for referral: 5/4/06
MM DO YYYYSignature: Lorraine Graves
Nurses SignatureName: Lorraine Graves
Printed178
124



Nursing Evaluation Tool:

General Sickfall

Facility: KEP
 Patient Name: Marshall, Carl
 Inmate Number: 110574
 Date of Report: 9-8-06
 Date of Birth: 8-6-50
 Time Seen: 600 AM/PM Circle One

Subjective: Chief Complaint(s): I need an order for my diabetic
shoes. Feet swell.
 Brief History: 58 y.o. Bm w/ Hx HTN, NIDDM, sarcoidosis

Objective: Vital Signs: (As Indicated) 98.9° 127 RR: 20 BP: 170/190
 Examination Findings: A+Ox3. Resp. Neg. & Abn. NAD

Assessment: (Referral Status) Preliminary Determination(s): Alt. in comfort R/T
☐ Referral NOT REQUIRED
☒ Referral REQUIRED due to the following: (Check all that apply)
☐ Recurrent Complaint more than 2 visits for the same complaint
☒ Other: Profile for shoes

Consent: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or a measure of the appropriate care to be given.

Plan: Check All That Apply:
☐ Instructions to return if condition worsens.
☐ Education: The patient demonstrates an understanding of the nature of his medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visit)
☐ Other:

OTC Medications given ☒ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, When/Where):

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):

Date for referral: 9-8-06
 AM/PM

L. Graves
 Nurse Signature

Name: Lorraine Graves
 Nurse



DEPARTMENT OF CORRECTIONS

TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record

Institution: _____

Date: _____ Time: _____ AM/PM

RECEIVED FROM:

Institution/Work Release Center/Free-World Hospital

RECEIVING MEDICAL STATUS

☐ Population☐ Infirmary☐ Isolation

RELEASED: Inmate/Health Record

Institution: KCFDate: 4/22/06 Time: _____ AM/PM

RELEASE FROM:

☐ Infirmary☐ Segregation☒ Population☐ Mental Health☐ Other _____

RELEASE TO:

☒ DOC☐ Infirmary☐ Mental Health☐ _____

Institution/Work Release Center/Free-World Hospital

ALLERGIES:

Tetracycline Clonidine

PHYSICAL EXAMINATION

Date of last exam: 4/21/06Chest X-Ray Date: _____ Result: SLMPPD Reading 4/24/06

Classification: _____

Limitations: _____

LAB RESULTS -- LAST REPORT

Treatments Completed

CBC

Urinalysis

RPR

Normal

Abnormal

☐☒☐☒

Wears Glasses/Contacts

Dental Prosthesis

Hearing Aide

Other Prosthesis

YES NO

☐ ☐☐ ☐☐ ☐☐ ☐

Receiving Nurse

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

HTN, DM

CURRENT MEDICATION -- DOSAGE AND FREQUENCY

Lisinopril 20mg PO QDGlucotrol 5mg PO QDSurfak 240mg PO QDEC ASA 325mg PO QDWellman 1000mg PO Bid Enox

SCHEDULE FOR CHRONIC CARE CLINIC

DATE: _____ LAST CLINIC: _____

MEDICATIONS

☒ Sent w / inmate☐ Not sent w / inmate

X-RAY FILM

☒ Sent w / inmate☐ Not sent w / inmate

HEALTH RECORD

☒ Sent w / inmate☐ Not sent w / inmateReleased to: DOCDate: 5-30-4 Time: 1530 AM/PM

MEDICATIONS

☐ Received☐ Not Received

X-RAY FILM

☐ Received☐ Not Received

HEALTH RECORD

☐ Received☐ Not Received

CHART REVIEWED

☒ YES☐ NO

Received by:

Signature of Receiving Nurse

Date: 5-30-4 Time: 1530 AM/PM

FOLLOW-UP CARE NEEDED

Date

Time

With Whom -- Location (Sending Nurse)

Date/Appt. Made w/Whom (Rec. Nurse)

☒ Medical☐ Dental☐ Mental HealthNURSING ASSESSMENT (SENDING NURSE)
(Noted from health record documentation)

	Yes	No
HISTORY		
Drug Use		<input checked="" type="checkbox"/>
Mental Illness		<input checked="" type="checkbox"/>
Suicide Attempt		<input checked="" type="checkbox"/>
Chronic Care	<input checked="" type="checkbox"/>	

STATUS		
Special Diet		<input checked="" type="checkbox"/>
Appearance		

OTHER PERTINENT NURSING ASSESSMENT

NURSING ASSESSMENT (RECEIVING NURSE)
(Noted from inmate assessment)

	Yes	No
SKIN		
Open Sores		<input checked="" type="checkbox"/>
Lice		<input checked="" type="checkbox"/>
Edema		<input checked="" type="checkbox"/>
Warm & Dry	<input checked="" type="checkbox"/>	
Cool & Moist		<input checked="" type="checkbox"/>

CONDITION		
Alert	<input checked="" type="checkbox"/>	
Oriented		<input checked="" type="checkbox"/>
Uncooperative		<input checked="" type="checkbox"/>
Depressed		<input checked="" type="checkbox"/>

INTAKE

Sick Call Procedures Explained OKHeight 6'3"Weight 230Blood Pressure 140/90Temperature 98.1Pulse Resp. 28/18

Other _____

Signature of Nurse Completing Assessment (Sending Nurse)

Date

Signature of Intake Screening Nurse (Receiving Nurse)

Date

INMATE NAME (LAST, FIRST, MIDDLE)

DOC#

DOB

Race/Sex

FAC



PHYSICIANS' ORDERS

NAME: Marshall, Carl

110574 5/4/06

D.O.B. 1/1

ALLERGIES: TCN, Clonidine

Use Last Date 5/4/06

DIAGNOSIS (If Chg'd) ⑤ Surfak 240mg p.o. QD x 30d

① ~~Clonidine 0.1mg p.o. now~~

② Re-✓ BP in 1 hour

③ Increase Lisinopril to 20mg p.o. BID x 180d

④ Decrease Glucotrol to 5mg p.o. QD x 180d

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Marshall, Carl

110574

D.O.B. 8/6/50

ALLERGIES:

Use Fourth Date 4/25/06

DIAGNOSIS (If Chg'd)

~~HgbA1c~~

Colan SR 180mg po qd x 180 days

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Marshall, Carl

110574

D.O.B. 8/6/50

ALLERGIES: TCN, clonidine

Use Third Date 4/25/06

DIAGNOSIS (If Chg'd)

Diabetes type 2 DM

Glucotrol 10mg po qd x 180 days

Lisinopril 20mg po qd x 180 days

ELASA 325mg po qd x 180 days

CC 4 wks B/P & BS Hx

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Marshall, Carl

110574

D.O.B. 8/6/50

ALLERGIES: TCN, Clonidine

Use Second Date 4/25/06

DIAGNOSIS (If Chg'd)

2200 Calorie DM diet & snack

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Marshall, Carl

110574

D.O.B. 8/6/50

ALLERGIES:

Use First Date 4/25/06

DIAGNOSIS

Cmp, Cho, PSA, HgbA1c, TSH, Uric Acid

ECG Cx

eye referral

BS R/Bid x 30 days

B/P v 2x wk x 4 wks

☐ GENERIC SUBSTITUTION IS NOT PERMITTED



PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
	Marshall, anfer Carl	1 1
5/4/06	F/u BS ✓'s . clo HTN . Requests stool softener .	
0850	BP : 199/105 this A.M.	
	BS ✓'s have been 44 - 296 mg/dL	
(HgbA1c - 7.8)	- He has 9 documented BS ✓'s in the 40's & Δ in PE	
	1) HTN	
	- Clonidine 0.1 mg now error / Re - ✓ in 7 hours	
	- Increase Lisinopril to 20 mg BID	
	- BP ✓'s	
	- CCC as sched.	
	2) NIDDM 2 episodes of hypoglycemia	
	- Decrease Glucotrol to Sug QD	
	- BS ✓'s	
	- CCC as sched.	
	3) Acute Constipation (x findings on PE)	
	- 9 fluids / fiber / exercise	
	- Sulfate x 30d	
	E: TX plan	
		Blum
5/5/06	needs TX for ⊕ RPR	
0820	x Bicillin LA avail. ; Allergic to TTC.	
	x consulted Dr. Robbins	
	- E-mycin 1gm BID x 30d	
	- medical hold	



PHYSICIANS' ORDERS

NAME:

DIAGNOSIS (If Chg'd)

D.O.B. / /

ALLERGIES:

Use Last Date / /

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

DIAGNOSIS (If Chg'd)

D.O.B. / /

ALLERGIES:

Use Fourth Date / /

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

DIAGNOSIS (If Chg'd)

D.O.B. / /

ALLERGIES:

Use Third Date / /

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

DIAGNOSIS (If Chg'd)

D.O.B.

ALLERGIES:

Use Second

Date

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

DIAGNOSIS

D.O.B.

ALLERGIES:

Use First

Date

☐ GENERIC SUBSTITUTION IS NOT PERMITTED



PHYSICIANS' ORDERS

NAME: Marshall, Carl 110574 D.O.B. 08/06/50 ALLERGIES: TCN, clonidine Use Last Date 12/11/06	DIAGNOSIS (If Chg'd) 1) Chem + lipid profile + Hg A, c ~ 10 weeks <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Marshall, Clark 110574 D.O.B. 08/06/50 ALLERGIES: TCN, clonidine Use Fourth Date 12/11/06	DIAGNOSIS (If Chg'd) Re med: 1) Glucotrol 5 mg p.o. BID x 80 days 2) Calan SR 150 mg p.o. BID x 80 days 3) Lipitor 20 mg p.o. BID x 80 days 4) CC AA 325 mg p.o. BID x 80 days V.O. Dr. K. [Signature] <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Marshall, Carl 110574 D.O.B. 8/6/50 ALLERGIES: TCN, clonidine Use Third Date 9/8/06	DIAGNOSIS (If Chg'd) ① Pt. may have diabetic shoes if approved by ADOC ② CCC - DM, HTN 1 month ③ BS ✓ 5 BID x 30d <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Marshall, Carl 110574 D.O.B. 8/6/50 ALLERGIES: TCN, clonidine Use Second Date 5/5/06	DIAGNOSIS (If Chg'd) Bicillin LA 2.4 mu IM qWK x 3 Wks D/C E-mycin Medical Hold until Cleared W. B. Adams CAMP / Graves, [Signature] <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Marshall, Carl 110574 D.O.B. 1/1 ALLERGIES: TCN, clonidine Use First Date 5/5/06	DIAGNOSIS ① E-mycin 1 gm p.o. BID x 30d ② Medical hold @ Kilby until cleared <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY



PRISON
HEALTH
SERVICES
INCORPORATED

PHYSICIANS' ORDERS

NAME:

DIAGNOSIS (If Chg'd)

D.O.B. / /

ALLERGIES:

Use Last Date / /

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

DIAGNOSIS (If Chg'd)

D.O.B. 8/6/98 110574

ALLERGIES: Tetracycline, Clonidine

Use Fourth Date 7/10/07 7-10-07

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

DIAGNOSIS (If Chg'd)

D.O.B. 8/6/98 110574

ALLERGIES: Tetracycline, Clonidine

Use Third Date 7/10/07

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

DIAGNOSIS (If Chg'd)

D.O.B. 8/6/98 110574

ALLERGIES: Tetracycline, Clonidine

Use Second Date 7/10/07

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

DIAGNOSIS

574 3/17/07 0939

D.O.B. 08/06/50

ALLERGIES: Tetracycline, Clonidine

Use First Date 3/10/07

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

Facility Name:		Month/Year of Charting:																																																
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																			
Pneumonia Vaccine																																																		
	Start Date: 7-10-7										Prescriber: my hood CRNP																																							
	Stop Date:										RX #:																																							
↑ Lisinopril to 40mg PO BID X90																																																		
	Start Date: 7-10-7										Prescriber: my hood CRNP																																							
	Stop Date: 9-10-7										RX #:																																							
Feas 325mg PO qd X90																																																		
	Start Date: 7-10-7										Prescriber: my hood CRNP																																							
	Stop Date: 9-10-7										RX #:																																							
Colace 100mg PO BID PRN X90																																																		
	Start Date: 7-10-7										Prescriber: my hood CRNP																																							
	Stop Date: 9-10-7										RX #:																																							
	Start Date:										Prescriber:																																							
	Stop Date:										RX #:																																							
	Start Date:										Prescriber:																																							
	Stop Date:										RX #:																																							
	Start Date:										Prescriber:																																							
	Stop Date:										RX #:																																							
Diagnosis	Nurse's Signature										Initial										Nurse's Signature										Initial										Documentation Codes									
Allergies																																									1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show									
Housing Unit:	110574																																																	
Patient ID Number:																																																		
Patient Name:	AA... 111 C 6																																																	



PRISON
HEALTH
SERVICES
INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 7/26/07

To: PHS - ADOC

From: PHS

Inmate Name: Marshall, Carl ID#: 110524

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra tray until see per MD @ DOC
every day
5. Other _____

Comments:

Extra food tray if hypoglycemic BS < 50.

Date: 7/26/07 MD Signature: [Signature] Time: 7:30 pm



PHYSICIANS' ORDERS

NAME: D.O.B. / / ALLERGIES: Use Last Date / /	DIAGNOSIS (If Chg'd) <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: D.O.B. / / ALLERGIES: Use Fourth Date / /	DIAGNOSIS (If Chg'd) <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: D.O.B. / / ALLERGIES: Use Third Date / /	DIAGNOSIS (If Chg'd) <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: D.O.B. / / ALLERGIES: Use Second Date / /	DIAGNOSIS (If Chg'd) <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: MARSHALL, Carl 110574 D.O.B. 8 16 198 ALLERGIES: cycloserine / clozapine Use First Date 8 27 07	DIAGNOSIS P ↑ Glucitol 10 mg BID QBS BID & placed No CRP Method / Sp... ③ Hold work <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED

ID: #STAT#060428092115

04/28/2006 9:21:14

D.O.B.: 8/6/58

Vent. Rate: 71 bpm

Meds:

RR Interval: 835 ms

Class:

PR Interval: 156 ms

Dr:

QRS Duration: 90 ms

Tech:

QT Interval: 384 ms

QTc Interval:

QTc Interval: 403 ms

QT Dispersion:

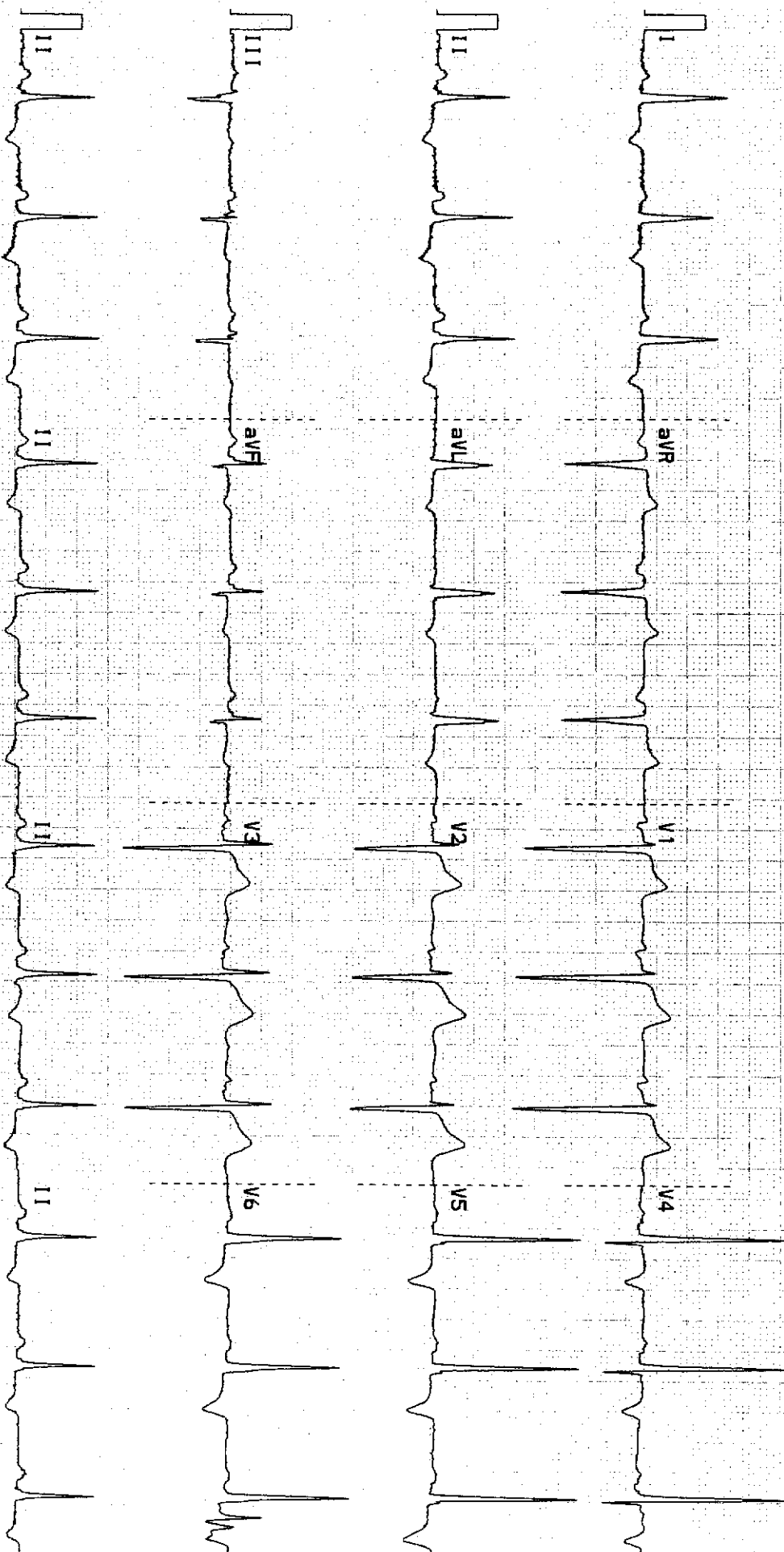
QT Dispersion: 30 ms

P-R-T AXIS:

P-R-T AXIS: 53° 13°-159°

Handwritten: 6/12 Int 230

SINUS RHYTHM
 ** INTERPRETATION MADE WITHOUT KNOWING PATIENT'S GENDER/AGE **
 Abnormally high SV1 + RV5
 LVH WITH SECONDARY REPOLARIZATION ABNORMALITY
 Extensive ST-T changes
 THESE CHANGES ARE PROBABLY DUE TO VENTRICULAR HYPERTROPHY
 Summary: ABNORMAL ECG
 * Unconfirmed Analysis *



L: 10 mm/mV
 C: 10 mm/mV

QTc=Hodges

Atr-a 3000 Int rel(20650204E(000+))

Serial # A3000 007143

25 mm/s
 STABLE 150 Hz

04/28/2006 9:21:34

ID: #STAT#060428092134

SINUS RHYTHM

** INTERPRETATION MADE WITHOUT KNOWING PATIENT'S GENDER/AGE **

Abnormally high SV1 + RV5
LVH WITH SECONDARY REPOLARIZATION ABNORMALITY

Extensive ST-T changes
THESE CHANGES ARE PROBABLY DUE TO VENTRICULAR HYPERTROPHY

Summary: ABNORMAL ECG

* Unconfirmed Analysis

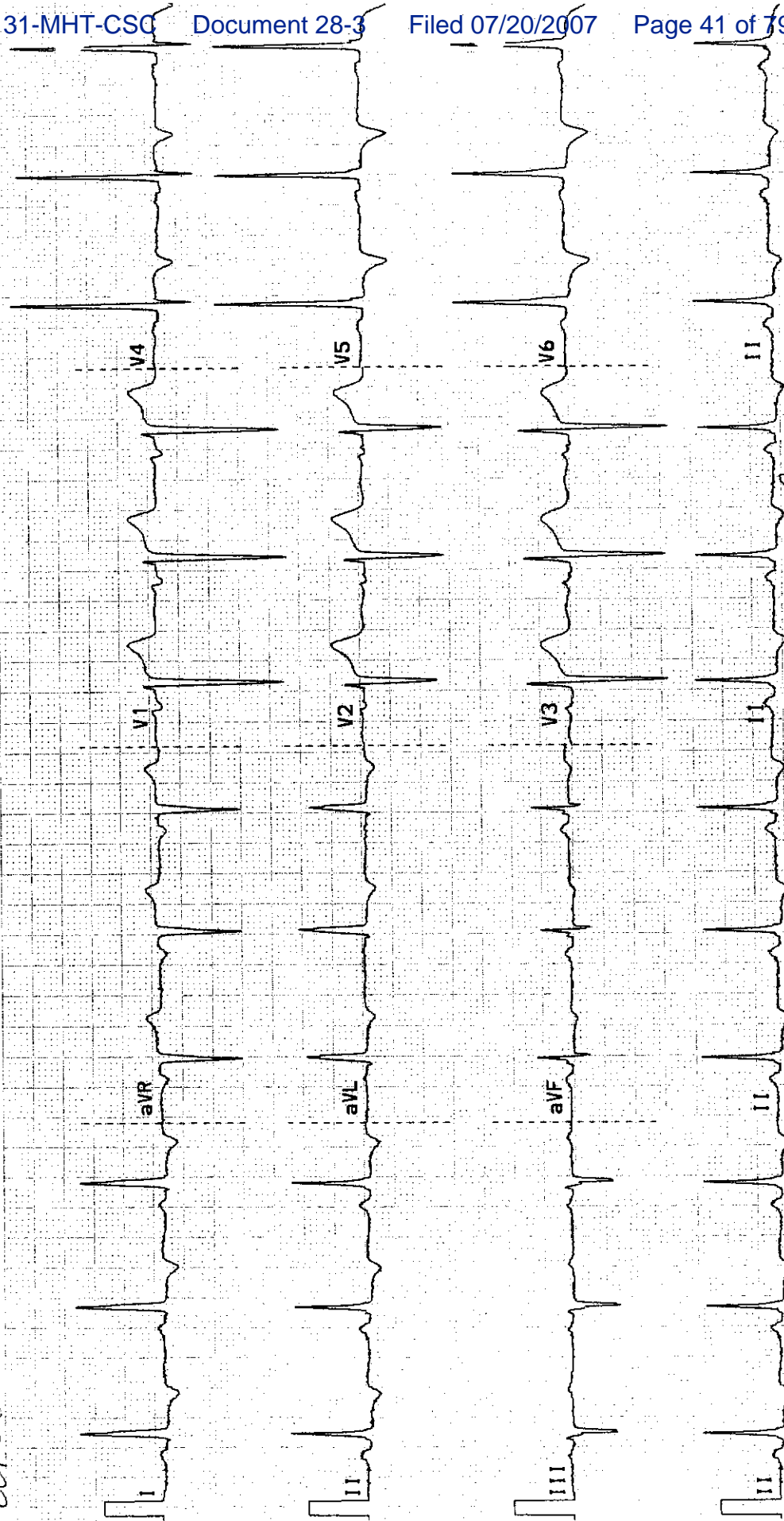
(P)

Vent. Rate:	72 bpm
RR Interval:	833 ms
PR Interval:	156 ms
QRS Duration:	90 ms
QT Interval:	400 ms
QTc Interval:	421 ms
QT Dispersion:	46 ms
P-R-T AXIS:	53° 13°-169°

Carl Marshall 110574

5/6

6/2 UA 230



Carl Marshall 110574

L: 10 mm/mV
C: 10 mm/mV

qTc=Hodges

Alto 3000 Int ref#20050202AE (0004)

Serial #A3000-007143

25 mm/s
~STABLE 150 Hz

TREATMENT REQUEST AND RECORD

Date of Request 4-25-6	Requested By PHYSICALS	Patient Status <input type="checkbox"/> IP <input type="checkbox"/> OP	Rx. Ordered
Clinical Diagnosis EXG			Date of Onset
			Date of Surgery

[illegible]

RECORD OF TREATMENT

[illegible]

Patient's Last Name	First	Middle	Age	R/S	ID No.
Marshall	Carl		55	B	110574

RADIOLOGY SERVICES REQUEST AND REPORT

INSTITUTION:

KCF

(PE)

DOB

8-6-50

Race:

B

Sex:

M

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP	Date of request	Time of request	Routine	Priority	Transportation or special needs
Lassiter	4-25-4				

HISTORY/DIAGNOSIS:

Protocol / DM / HTN

X-RAY REQUEST

ABDOMEN/KUB	FINGERS	NAVICULAR VIEW	SOFT TISSUE STUDIES
ACIOMIO-CLAVICULAR JOINTS (W/WO WEIGHT)	FOOT	ORBITS	STERNUM
ANKLE	HAND	OF CALCUS (HEEL)	TEMPORO-MANDIBULAR JOINTS
CERVICAL SPINE	HIP	PELVIS	THORACIC SPINE
<input checked="" type="checkbox"/> CHEST PA / LATERAL	HUMERUS	RADICULUS	TIBIA/FIBULA
COCCYX	KNEE	RIBS	TOES
CONE DOWN SELLA TURCICA	LUMBAR SPINE	SACRO-ILIAC JOINTS	WRIST
ELBOW	MANDIBLE	SCAPULA	ZYGOMA
FACIAL BONES	MAXILLA	SHOULDER	ZYGOMATIC ARCH
FEMUR	NASAL BONES	SKULL	

REPORT

Carl Marshall

Marshall

Chest: The heart is not enlarged. The lungs are clear.

IMPRESSION: THERE IS NO EVIDENCE OF ACTIVE CARDIOPULMONARY DISEASE.

D: & T: 04-27-08 Thomas J. Payne, III, M.D./jhl Board Certified Radiologist (Signature on file)

J5-206

X-RAY TECHNOLOGIST'S NAME (PRINT)

X-RAY TECHNOLOGIST'S SIGNATURE

DATE, TIME EXAM PERFORMED

RADIOLOGIST'S NAME (PRINT)

RADIOLOGIST'S SIGNATURE

DATE SIGNED

DENTAL RECORD TREATMENT

[illegible]

PATIENT LAST NAME	FIRST	MIDDLE	DOB	R/S	ID NO.
-------------------	-------	--------	-----	-----	--------



DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES

DENTAL RECORD

DENTAL EXAMINATION	RESTORATIONS AND TREATMENTS
Date of Initial Examination <u>4-25-06</u>	Initial Classification

Oral Pathology Gingivitis
 Vincent's Infection
 Stomatitis
 Other Findings 8, 9 - Lesion

Occlusion

Roentgenograms Periapical
 Bitewing
 Other

Health Questionnaire

YES NO

☐ ☒ Rheumatic Fever
☐ ☒ Allergy (Novocaine, penicillin, etc.)
☐ ☒ Present Medication
☐ ☒ Epilepsy
☐ ☒ Asthma
☒ ☐ Diabetes
☐ ☒ HIV

YES NO

☐ ☒ V.D.
☐ ☒ Hepatitis
☐ ☒ Anemia or Bleeding Problems
☐ ☒ Heart Disease
☒ ☐ High Blood Pressure
☐ ☒ Kidney Disease
☒ ☐ Other Disease

SERVICES RENDERED

Date	Tooth #	DX	TX	Initials	Class
4-25-06	Fm		OHI	gtr	

INMATE NAME (LAST, FIRST, MIDDLE)

DOC#

DOB

R/S

FAC.

Marshall, Carl1105748-6-50MDKCF

NAME: MARSHALL, CARL

INSTITUTION/FACILITY: ELBA
I.D. # 110574 D.O.B.: 8/6/48

CELL SITE:

PHYSICIAN ORDER/INSTRUCTIONS:

[illegible]

*Check if results called to physician.

[illegible]

Date	Initials	Signatures

ALABAMA DEPARTMENT OF CORRECTIONS

PROBLEM LIST

INMATE NAME Marshall, Carl AIS# 110574Medication Allergies: Tetracycline, ClonidineMedical: Chronic (Long-Term) Problems
Roman Numerals for Medical/SurgicalMental Health Code: SMI HARM HIST NONE
Capital Letter for Psychiatric Behavior

Date Identified	Chronic Medical Problem	Mental Health Code	Date Resolved	Provider Initials
4/25/06	HTN			st
4/25/06	DM			st
4/24/06	PPD qmm			st
11/2/06	<small>Adjuvanted Influenza Vaccine FLUARIX®</small> LOT AFLUA210BA EXP. 00730/07		11/2/06	cy

**If Asthmatic label: Mild – Moderate – or Severe.

ACCESSION NO. NPY8/110574	NAME CARL MARSHALL	FACILITY Kilby
------------------------------	-----------------------	-------------------

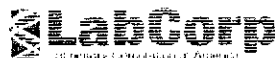
DATE COLLECTED 4/25/06	TIME COLLECTED 8:30 AM
---------------------------	---------------------------

DATE RECEIVED 4/25/06	TIME RECEIVED 8:30 AM
--------------------------	--------------------------

Test Name	Result	Out of Range	Reference Range
HIV ANTIBODY	NEG		NEGATIVE (NEG)
RPR		R	NON-REACTIVE (NR)
URINALYSIS			
PROTEIN	NEG		NEGATIVE (NEG)
GLUCOSE		POS 3+	NEGATIVE (NEG)
KETONES	NEG		NEGATIVE (NEG)
BILIRUBIN	NEG		NEGATIVE (NEG)
BLOOD	NEG		< 5 RBC/MCL (NEG)
NITRITE	NEG		NEGATIVE (NEG)
UROBILINOGEN	NEG		< 1.0 MG/DL (NEG)
LEUK. ESTERASE	NEG		NEGATIVE (NEG)

* NT = Not Tested





LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000

Phone 205-581-3500

SPECIMEN TYPE PRIMARY LAB REPORT STATUS
116-205-5622-0 S MB COMPLETE Page #: 1

ADDITIONAL INFORMATION

PES 4/25 FASTING: N
DOB: 8/06/1950

CLINICAL INFORMATION

CD-41139330308

PATIENT NAME SEX AGE(YR./MOS.)
MARSHALL, CARL M 55 / 8
PT. ADDR:

PHYSICIAN ID. PATIENT ID.
ROBBINS M 110574

ACCOUNT: Kilby Correctional Facility
Prison Health Services
12201 Wares Ferry Road
Mt. Meigs AL 36507-0000

DATE OF COLLECTION TIME DATE RECEIVED DATE REPORTED TIME
4/26/2006 10:32 4/26/2006 4/27/2006 11:23 9836

ACCOUNT NUMBER: 01306900

TEST	RESULT	LIMITS	LAB
CMP14+LP+5AC			
Chemistries			
> Glucose, Serum	128 H mg/dL	65 - 99	MB
Uric Acid, Serum	6.0 mg/dL	2.4 - 8.2	MB
BUN	18 mg/dL	5 - 26	MB
Creatinine, Serum	1.0 mg/dL	0.5 - 1.5	MB
BUN/Creatinine Ratio	18	8 - 27	
Sodium, Serum	140 mmol/L	135 - 148	MB
Potassium, Serum	3.9 mmol/L	3.5 - 5.5	MB
Chloride, Serum	102 mmol/L	96 - 109	MB
Carbon Dioxide, Total	24 mmol/L	20 - 32	MB
Calcium, Serum	10.2 mg/dL	8.5 - 10.6	MB
Phosphorus, Serum	3.2 mg/dL	2.5 - 4.5	MB
Protein, Total, Serum	7.8 g/dL	6.0 - 8.5	MB
Albumin, Serum	4.3 g/dL	3.5 - 5.5	MB
Globulin, Total	3.5 g/dL	1.5 - 4.5	
A/G Ratio	1.2	1.1 - 2.5	
Bilirubin, Total	0.3 mg/dL	0.1 - 1.2	MB
Alkaline Phosphatase, Serum	58 IU/L	25 - 150	MB
LDH	175 IU/L	100 - 250	MB
AST (SGOT)	18 IU/L	0 - 40	MB
ALT (SGPT)	27 IU/L	0 - 55	MB
GGT	48 IU/L	0 - 65	MB
Iron, Serum	68 ug/dL	40 - 155	MB
Lipids			
Cholesterol, Total	154 mg/dL	100 - 199	MB
> Triglycerides	251 H mg/dL	0 - 149	MB
> HDL Cholesterol	33 L mg/dL	40 - 59	MB
> VLDL Cholesterol Cal	50 H mg/dL	5 - 40	
LDL Cholesterol Calc	71 mg/dL	0 - 99	
T. Chol/HDL Ratio	4.7 ratio units	0.0 - 5.0	
Estimated CHD Risk	0.9 times avg.	0.0 - 1.0	

T. Chol/HDL Ratio
Men Women
1/2 Avg. Risk 3.4 3.3
Avg. Risk 5.0 4.4
2X Avg. Risk 9.6 7.1
3X Avg. Risk 23.4 11.0

Pat Name: MARSHALL, CARL

Pat ID: 110574

Spec #: 116-205-5622-0

Seq #: 9836

Results are Flagged in Accordance with Age Dependent Reference Ranges

Continued on Next Page





LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000

Phone: 205-581-3500

SPECIMEN TYPE PRIMARY LAB REPORT STATUS
116-205-5622-0 S MB COMPLETE Page #: 2

ADDITIONAL INFORMATION

CLINICAL INFORMATION

PE8 4/25 FASTING: N
DOB: 8/06/1950

CD- 41139330308

PATIENT NAME
MARSHALL, CARL
PT. ADD.:

SEX AGE(YR./MOS.)
M 55 / 8

PHYSICIAN ID. PATIENT ID.
ROBBINS M 110574

ACCOUNT: Kilby Correctional Facility
Prison Health Services
12201 Wares Ferry Road
Mt. Meigs AL 36507-0000

DATE OF COLLECTION TIME DATE RECEIVED DATE REPORTED TIME
4/26/2006 10:32 4/26/2006 4/27/2006 11:23 9836

ACCOUNT NUMBER: 01306900

TEST RESULT LIMITS LAB

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of pre-mature CHD.

Microalb/Creat Ratio, Randm Ur

Creatinine, Urine 169.6 mg/dL Not Estab. MB

> Microalbum., U, Random 499.8H ug/mL 0.0 - 17.0 MB

> Microalb/Creat Ratio 294.7H ug/mg creat 0.0 - 30.0

Hemoglobin A1c

> A1c 7.8H % 4.5 - 5.7 MB

Current guidelines recommend a treatment goal of <7% for diabetic patients. A1c may be overestimated in diabetic patients exhibiting poor control and who are also heterozygous or homozygous for HgbS or HgbC. Total glycohemoglobin is a better indicator of diabetic control in patients with these hemoglobin variants.

Prostate-Specific Ag, Serum

Prostate-Specific Ag, Serum 0.2 ng/mL 0.0 - 4.0 MB

Beckman (formerly Hybritech) ICMA methodology

TSH 1.067 uIU/mL 0.350 - 5.500 MB

LAB: MB LabCorp Birmingham

DIRECTOR: John Elgin N MD

1801 First Avenue South, Birmingham, AL 35233-0000



Bureau of Clinical Laboratories-MontgomeryPO BOX 244018, MONTGOMERY AL 36124-4018
Phone:(334) 260-3400 FAX:(334) 274-9800

Page: 1

Provider:KILBY CORRECTIONAL FACILITY
P O BOX 150
MT MEIGS, AL, 36057-0000
(334) 215-6600
MONTGOMERY CO HD**Accession**4022235
Requisition #: 4022235
Service Area:
CHR #:**ID:**

1028940

Patient:**Marshall, Carl,**

D.O.B.: 8/ 6/1950

Sex: M MALE

Phone: (000) 000-0000

Collected: 4/25/2006 @

Received: 4/26/2006 @ 8:27 AM

Reported: 5/ 1/2006 @ 3:31 PM

Status: Final Report**Test Name****Result****Units****Normal Range****Notes****Serology Results**

- ~ VDRL, STS Quantitative **Reactive 32 dils.** A
- ~ TP-PA Result **Reactive** A

Report Summary**Abnormal Summary**

- ~ VDRL, STS Quantitative **Reactive 32 dils.** A
- ~ TP-PA Result **Reactive** A

*No treatment history 1 B TX finished 5/22/06 J***Lab Director****William J. Callan, Ph.D.***needs TX.*
(P)

Bureau of Clinical Laboratories - Montgomery

PO BOX 244018, MONTGOMERY AL 36124-4018

Phone:(334) 260-3400 FAX:(334) 274-9800

Page: 1

Provider:

KILBY CORRECTIONAL FACILITY
P O BOX 150
MT MEIGS, AL, 36057-0000
(334) 215-6600,
MONTGOMERY CO HD

Accession

Requisition #: 4027103
Service Area:
CHR #:

4027103**ID:****1039432****Patient:****Marshall, Carl**

D.O.B.: 8/ 6/1950

Sex: M MALE

Phone: (000) 000-0000

Collected: 6/ 2/2006 @

Received: 6/ 9/2006 @ 10:55 AM

Reported: 6/13/2006 @ 3:17 PM

Status: Final Report**Test Name****Result****Units****Normal Range****Notes****Serology Results**

VDRL, STS Quantitative

Reactive 32 dils.**A**

TP-PA Result

Reactive**A****Report Summary****Abnormal Summary**

VDRL, STS Quantitative

Reactive 32 dils.**A**

TP-PA Result

Reactive**A****Lab Director****William J. Callan, Ph.D.**

Date Printed: 6/13/2006

3:17 PM

>> PH - Panic High

>

AH - Abnormal High

~

A - Abnormal

*** Final Page ***

Completed Between: 6/12/2006

- 6/13/2006

<< PL - Panic Low

<

AL - Abnormal Low

§

Delta Check Failed

All Results Included

ACCESSION NO.	NAME	FACILITY
123/110574	CARL MARSHALL	REHF

DATE COLLECTED	TIME COLLECTED	DATE RECEIVED	TIME RECEIVED
6/2/06	8:30 AM	6/7/06	8:30 AM

Test Name	Result	Out of Range	Reference Range
HIV ANTIBODY	NT		NEGATIVE (NEG)
RPR		R	NON-REACTIVE (NR)
URINALYSIS			
PROTEIN	NT		NEGATIVE (NEG)
GLUCOSE	NT		NEGATIVE (NEG)
KETONES	NT		NEGATIVE (NEG)
BILIRUBIN	NT		NEGATIVE (NEG)
BLOOD	NT		< 5 RBC/MCL (NEG)
NITRITE	NT		NEGATIVE (NEG)
UROBILINOGEN	NT		< 1.0 MG/DL (NEG)
LEUK. ESTERASE	NT		NEGATIVE (NEG)

* NT = Not Tested

(Signature)

BioReference
LABORATORIES

DOCTOR	KILBY CORR. FACILITY 12201 WARES FERRY RD. MONTGOMERY, AL 36507		BOOK/CASE:		
	(A0110-0) Bio-Net Print		-FINAL- Original Report 02/22/2007		
NAME MARSHALL, CARL		PATIENT I.D. / ROOM NO. 110574.2959		DOCTOR / GROUP NAME ROBBINS, MICHAEL	
LAB I.D. NO. 103762211	DATE COLLECTED 02/20/2007 08:49 AM	DATE RECEIVED 02/21/2007 10:06 3	DATE OF REPORT 7/7/2007 08:50	AGE 56 Y	SEX M

Test Description	Result	Abnormal	Reference Range
------------------	--------	----------	-----------------

GFR (Glomerular Filtration Rate) calculation utilizes the MDRD formula (Modification of Diet in Renal Disease Study Group) and assumes a normal adult body surface area of 1.73. If the patient is African American multiply result reported by 1.21. (Ref. National Kidney Disease Educa. Program.)

***** Male/Female reference range: >60 mL/min/1.73 m2 *****

Note: A calculated GFR of <60 mL suggests chronic kidney disease, but only if found consistently over at least 3 months. A calculated result of <15 mL is consistent with renal failure.

-----* MISCELLANEOUS *

HGB. A1c(glycohgb)

9.4 HI < 6.0%

HEMOGLOBIN A1c RANGES(%)

< 6.0%
< 7.0%
> 8.0%

GLUCOSE-CONTROL INDEX

Non-Diabetic Level

Diabetic Control

Additional action suggested

Final Report

Page: 2

BioReference
LABORATORIES

D O C T O R	KILBY CORR. FACILITY 12201 WARES FERRY RD. MONTGOMERY, AL 36507		BOOK/CASE:	
	(A0110-0) Bio-Net Print		-FINAL- Original Report 02/22/2007	
NAME MARSHALL, CARL		PATIENT I.D. / ROOM NO. 110574.2959		DOCTOR / GROUP NAME ROBBINS, MICHAEL
LAB I.D. NO. 103762211	DATE COLLECTED 02/20/2007 08:49 AM	DATE RECEIVED 02/21/2007 10:06	DATE OF REPORT 3/7/2007 08:50	AGE 56 Y SEX M

Test Description	Result	Abnormal	Reference Range
------------------	--------	----------	-----------------

Tests Ordered : HEMOGLOBIN A1C, DIAGNOSTIC PROFILE I, ,

-----* CHEMISTRY *-----

Total Protein	7.6		5.9-8.4	gm/dl
Albumin	4.1		3.2-5.2	gm/dl
Globulin	3.5		1.7-3.7	gm/dL
A/G Ratio	1.2		1.1-2.9	
Glucose		162 HI	70-109	mg/dL
Sodium	140		133-145	mmol/L
Potassium	4.3		3.3-5.3	mmol/L
Chloride	102		96-108	mmol/L
CO2	26		21-29	mmol/L
BUN	17		7-25	mg/dl
* Creatinine	1.1		0.6-1.3	mg/dl
BUN/Creat Ratio	15.5		10-28	
Calcium	9.9		8.4-10.4	mg/dl
Uric Acid	5.2		2.4-7.0	mg/dl
Iron	75		30-160	mcg/dl
Bilirubin, Total	0.2		0.1-1.0	mg/dl
LDH	162		94-250	u/l
Alk Phos	91		39-120	u/l
AST (SGOT)	16		< 37	u/l
Phosphorous	3.3		2.6-4.5	mg/dl
ALT (SGPT)	17		< 40	u/L
G-GTP	47		7-51	u/L
Cholesterol	186		< 200	mg/dl
Triglycerides		213 HI	< 151	mg/dl
HDL CHOL., DIRECT	36		>35	mg/dl
HDL as % of Cholesterol		19		%
Chol/HDL Ratio		5.17		
LDL/HDL Ratio	3		0-3.55	
LDL Cholesterol		108 HI	< 100	mg/dL

* GFR, Estimated = 73.44 mL/min/1.73m2

Continued on Next Page

Page: 1



9/6/50

Marshall, Carl

Facility Name:		Month/Year of Charting:																														
Surfak 240mg PO QD x 30d	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date: 5/4/06		Prescriber:																														
Stop Date: 6/4/06		RX #:																														
E-mycin 1gm PO BID x 30d	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date: 5/5/06		Prescriber:																														
Stop Date: 6/5/06		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes																											
Allergies: Tetracycline, Clonidine					1. Discontinued Order																											
Housing Unit:					2. Refused																											
Patient ID Number:					3. Patient out of facility																											
Patient Name: Marshall, Carl					4. Charted in Error																											
					5. Lock Down																											
					6. Self Administered																											
					7. Medication out of Stock																											
					8. Medication Held																											
					9. No Show																											
					10. Other																											

Facility Name:	Month/Year of Charting																																																																
KCF	9/6																																																																
Calan SR 180mg	<table border="1"> <tr> <th>Hour</th> <th>1</th><th>2</th><th>3</th><th>4</th><th>5</th><th>6</th><th>7</th><th>8</th><th>9</th><th>10</th><th>11</th><th>12</th><th>13</th><th>14</th><th>15</th><th>16</th><th>17</th><th>18</th><th>19</th><th>20</th><th>21</th><th>22</th><th>23</th><th>24</th><th>25</th><th>26</th><th>27</th><th>28</th><th>29</th><th>30</th><th>31</th> </tr> <tr> <td>0300</td> <td colspan="31">[Signature]</td> </tr> </table>	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	0300	[Signature]																														
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																																		
0300	[Signature]																																																																
Glucotrol 10mg 3 po qd x 180d.	<table border="1"> <tr> <td>Start Date:</td> <td>4/25/6</td> <td>Prescriber:</td> <td>Fursten</td> </tr> <tr> <td>Stop Date:</td> <td>10/26/6</td> <td>Rx #:</td> <td></td> </tr> </table>	Start Date:	4/25/6	Prescriber:	Fursten	Stop Date:	10/26/6	Rx #:																																																									
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Lisinopril 20mg 3 po qd x 180d.	<table border="1"> <tr> <td>Start Date:</td> <td>4/25/6</td> <td>Prescriber:</td> <td>Fursten</td> </tr> <tr> <td>Stop Date:</td> <td>10/26/6</td> <td>Rx #:</td> <td></td> </tr> </table>	Start Date:	4/25/6	Prescriber:	Fursten	Stop Date:	10/26/6	Rx #:																																																									
Start Date:	4/25/6	Prescriber:	Fursten																																																														
Stop Date:	10/26/6	Rx #:																																																															
ECN 325mg 3 po qd x 180d.	<table border="1"> <tr> <td>Start Date:</td> <td>4/25/6</td> <td>Prescriber:</td> <td>Fursten</td> </tr> <tr> <td>Stop Date:</td> <td>10/26/6</td> <td>Rx #:</td> <td></td> </tr> </table>	Start Date:	4/25/6	Prescriber:	Fursten	Stop Date:	10/26/6	Rx #:																																																									
Start Date:	4/25/6	Prescriber:	Fursten																																																														
Stop Date:	10/26/6	Rx #:																																																															
Lisinopril 20mg po BID x 180d	<table border="1"> <tr> <td>Start Date:</td> <td>5/4/06</td> <td>Prescriber:</td> <td></td> </tr> <tr> <td>Stop Date:</td> <td>11/4/06</td> <td>Rx #:</td> <td></td> </tr> </table>	Start Date:	5/4/06	Prescriber:		Stop Date:	11/4/06	Rx #:																																																									
Start Date:	5/4/06	Prescriber:																																																															
Stop Date:	11/4/06	Rx #:																																																															
Glucotrol 5mg po QD x 180d	<table border="1"> <tr> <td>Start Date:</td> <td>5/4/06</td> <td>Prescriber:</td> <td></td> </tr> <tr> <td>Stop Date:</td> <td>11/4/06</td> <td>Rx #:</td> <td></td> </tr> </table>	Start Date:	5/4/06	Prescriber:		Stop Date:	11/4/06	Rx #:																																																									
Start Date:	5/4/06	Prescriber:																																																															
Stop Date:	11/4/06	Rx #:																																																															

Diagnosis	Nurse's Signature	Initial	Nurse's License #	Unit	Documentation
Allergies Tetracycline, clonidine	[Signature]	MR	L. Smith	AD	<input type="checkbox"/> Discontinued Order <input type="checkbox"/> Refused <input type="checkbox"/> Patient not found <input type="checkbox"/> Chart not found <input type="checkbox"/> Other
Housing Unit:					
Patient ID Number:	118574				
Patient Name:					

Marshall, Paul

Diagnosis	Nurse's Signature	Initial	Nurse's S. Signature	Initial	Documentation Codes Documentation On
Allergies: TCN, clonidine					<input type="checkbox"/> Re-use <input type="checkbox"/> Patient on a regular <input type="checkbox"/> Patient on a <input type="checkbox"/> Not recommended <input type="checkbox"/> Not recommended <input type="checkbox"/> Not recommended <input type="checkbox"/> Not recommended
Housing Unit:					
Patient ID Number:					
Patient Name: 110574					
Marshall, Carl					

Facility Name:	Month/Year of Charting:
5/16/	5/06
Calan SR 180mg	0300
Start Date: 4/23/06	Prescriber: Lassiter
Stop Date: 10/26/06	RX #:
Glucetrol 5mgm ÷ po qd x 180d	0300
Start Date: 5/4/06	Prescriber: Lassiter
Stop Date: 11/4/06	RX #:
Lisinopril 20mg ÷ po Bid x 180d	0300
Start Date: 5/4/06	Prescriber: Lassiter
Stop Date: 11/4/06	RX #:
ELA 325mg ÷ po qd x 180d	0300
Start Date: 4/23/06	Prescriber: Lassiter
Stop Date: 10/26/06	RX #:
Sur Fak 240mg po qd x 300	0300
Start Date: 5/4/06	Prescriber:
Stop Date: 6/14/06	RX #:

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
Allergies: Tetracycline Clonidine	N. Hughes	NA	A. Smith	NA	1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Stock 10. Other
Housing Unit:					
Patient ID Number:					
Patient Name:					
Marshall, Carl					

Facility Name: Kilby Correctional Facility

Month/Year of Charting: 06/06

Calan SR 180MG Tab CR 30.00

Take 1 tablet(s) by mouth daily

Start Date: 04-27-2006

Prescriber: Lassiter, L.

Stop Date: 10-23-2006

RX #: 251448650

Glucotrol 10MG Tab 30.00

Take 1 tablet(s) by mouth daily

Start Date: 04-27-2006

Prescriber: Lassiter, L.

Stop Date: 10-23-2006

RX #: 251448653

Lisinopril 20MG Tab 30.00

Take 1 tablet(s) by mouth daily

Start Date: 04-27-2006

Prescriber: Lassiter, L.

Stop Date: 10-23-2006

RX #: 251448658

Aspirin EC 325MG EC Tab 30.00

Take 1 tablet(s) by mouth daily

Start Date: 04-27-2006

Prescriber: Lassiter, L.

Stop Date: 10-23-2006

RX #: 251448660

Glucotrol 5mg
+ po gel x 180d

Start Date: 5-4-06

Prescriber: LR

Stop Date: 11-4-06

RX #:

Surfak 240mg
po gel x 30d

Start Date: 5-4-06

Prescriber:

Stop Date: 6-4-06

RX #:

Diagnosis

Nurse's Signature

Initial

Nurse's Signature

Initial

Documentation Codes

Allergies

Housing Unit:

Population

Patient ID Number: 110574

Patient Name

Marshall, Carl

1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Signs
10. Other

C A N T E E N S A L E S R E C E I P T

MARSHALL, CARL V. 110574 B/M 5/03/2006 9:12AM TRANS NR 87475

LI	ITEM NBR	ISSUE QTY	DESCRIPTION	UI	UNIT COST	EXTENDED COST
1	808	6	.39 STAMPS	EA	\$.39	\$2.34
2	700	20	BOOK MATCHES	EA	\$.02	\$.40
3	602	3	DORAL MENTHOL 100	EA	\$4.26	\$12.78
4	607	1	KOOL FILTER KING	EA	\$4.65	\$4.65
5	611	1	NEWPORT KING	EA	\$4.65	\$4.65
6	623	3	BUGLER TOBACCO	EA	\$1.08	\$3.24
7	626	3	TOP MENT CIG TOBACCO	EA	\$1.09	\$3.27
8	430	1	COAST SOAP (BATH)	EA	\$.92	\$.92
9	806	1	BIC CLEAR BARREL-BLK	EA	\$.75	\$.75
10	211	1	MARUCHAN CHICK SOUP	EA	\$.47	\$.47
11	212	1	MARUCHAN SHRIMP SOUP	EA	\$.47	\$.47
12	119	240	STARDROPS CANDY	EA	\$.01	\$2.40
13	131	1	THREE MUSKETEER	EA	\$.57	\$.57
14	134	1	HERSHEY PLAIN	EA	\$.57	\$.57
15	137	1	MILKY WAY	EA	\$.57	\$.57

**** LAST ITEM ****

TOTAL PURCHASES \$38.05

OLD PMOD BALANCE 51.49 TOTAL PURCHASE 38.05 NEW PMOD BALANCE 13.44

TOTAL APPLIED TO WEEKLY LIMIT 7.12 POSTED BY: PATTI P VERMILYER

I CERTIFY THAT I RECEIVED ALL ITEMS AND QUANTITIES LISTED ABOVE.

SIGNATURE

DATE

BED NBR: M 086B

MARSHALL, CARL V. 110574 B/M 5/01/2006 3:52PM TRANS NR 86682

LI	ITEM NBR	ISSUE QTY	DESCRIPTION	UI	UNIT COST	EXTENDED COST
1	960	3	COKE	EA	\$.52	\$1.56
2	902	3	GOLDEN FLAKE BBQ	EA	\$.31	\$.93
3	924	2	MICROWAVE POPCORN	EA	\$.50	\$1.00
4	904	1	ICE CREAM	EA	\$1.30	\$1.30
***** LAST ITEM *****						=====
TOTAL PURCHASES						\$4.79

OLD PMOD BALANCE 62.11 TOTAL PURCHASE 4.79 NEW PMOD BALANCE 57.32
TOTAL APPLIED TO WEEKLY LIMIT .00 POSTED BY: INMATE WORKERS

I CERTIFY THAT I RECEIVED ALL ITEMS AND QUANTITIES LISTED ABOVE.

SIGNATURE

DATE

BED NBR: M 086B



DIABETIC CHECKLIST

Name Marshall Carl Number 110574 Period 4/06 to 4/07
Glucophage 500mg P.O. QD 3/7/07 Glucophage 500mg P.O. QD
 Medications: EC ASA 325 P.O. QD

Compliance: ☒ Yes ☐ No

If No, follow-up counseling done: Yes No Date _____

Enrolled in Chronic Care: ☒ Yes ☐ NoMonofilament Foot Exams Done: ☒ Yes ☐ No

Foot Disorders Treated: Yes No

Educational Material Given: ☒ Yes ☐ No

Appropriate Diet Ordered: Yes No

Regular Glucose Testing: Yes No

HgbA1C done q 3 months: Yes No Every 6 months if stable

Seen by dental at least annually: Yes No

Urine tested annually for microalbumin Yes No

Seen by Nurse: 12/11/06, 3/27/07Seen by MD: 2/11/07, 3/27/07

Annual dilated retinal exam _____ By _____

Referral if necessary _____

Immunization:

Pneumococcus once and repeated after age 64, if more than 5 yrs. Yes No

Influenza annually 11/2/06 Yes No

Annual physical exam by MD/NP Yes No Date _____

Individual treatment plan Yes No

Updated Yes No

Appropriate Diet Ordered: Yes No

ADOC notified: Yes No



**DIABETIC INTAKE SCREENING
FOR INTAKES THAT PRESENT WITH DIABETES
Referral to MD and Seen within 24 hrs of Intake**

NAME Marshall, Carl Number 110574 Date 4/25/06

Diagnosed with diabetes? Yes No

If yes, then H & P by licensed health care provider with prescriptive authority.

If yes, date H & P completed _____ by _____

Random plasma glucose test results 179 Date 4/25/06

If level > 200, then second test within 48 hours

Repeat results 156 Date 4/25/06

If level < 200, record flagged for a fasting glucose plasma test upon arrival at first assigned institution.

History of fasting Blood Sugar? Yes No Results/Date Not avail

History or Frequency of:

Ketoacidosis	<u>Yes</u>	No	<u>x 4 since dx</u>
Hypoglycemia	<u>Yes</u>	No	<u>"most mornings"</u>
Hypoglycemia w/o awareness	<u>Yes</u>	No	<u>periodically 7 x 8 days</u>
History of known complications	Yes	<u>No</u>	

Screening Laboratory Evaluation (at reception) All diabetic receive:

Test	Date	Results in MR	Reviewed
HgbA1c upon arrival			
HDL--Cholesterol *			
Triglycerides *			
Total Cholesterol *			
Urine for microalbumin #140050--24 hr urine			
UA for protein & ketones (onsite)			
Serum Creatinine *			
TSH (when indicated) *			
EKG (onsite)	<u>4-25-06</u>		
Fundoscopy Exam			
Peripheral Pulses			

* Diagnostic profile II-(048827)-Includes Chem 7, Ca++, LFT's, Lipid Panel, Fe, Phos, Total Protein, Uric acid, Globulin, Transepsidase, Thyroid Panel, CBC w/Diff

Determination of Diabetes ----circle one----Type I Type II

Initial Treatment Plan by MD.....YES NO

Refer to Chronic Care Clinic within 7 days of

Diabetic diet..... YES NO Informed ADOC YES NO

Education: Documented in medical record.....Date _____

Reviewed by _____ Date _____

Physician's Chronic Care Clinic

Date: 4/28/06 Time: 1230 Facility: Kilby Correctional Facility

Check all applicable CIC's being evaluated: ☒ Card/HTN ☒ DM ☐ GI ☐ ID ☐ PUL ☐ SZ ☐ TB

SUBJECTIVE: Dr & DM @ 12yo no med x 4 dys (4:15 AM)
Dr & HTN @ 1969 taking med @ that time. ④ DCUA x 3, ④ DM x 2 (1997)
 was on

OBJECTIVE: BP 180/110 HR 68 RR 20 Temp 98.6 Wt 240 Peak Flow 750
 NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ
 Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds,
 Cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT,
 Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

40HA, Denies SOB, Visual disturbances, CP or other Sx

S, S reg 5(10); ④ Brn H; ④ BBS clay Resp c ear. ④ putidial edema

④ Cigs

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
 Status: I=Improved, S=Stable, W=Worsened

DM	HTN/CARD	SZ	PUL	ID	GI	OTHER
Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control
G F P	G F P	G F P	G F P	G F P	G F P	G F P
Status	Status	Status	Status	Status	Status	Status
I S W	I S W	I S W	I S W	I S W	I S W	I S W

PLAN: Will place on Glucostrol, Calan[®] Lisinpril, ASA; 4u p BS/BPV
Discuss Cigs; Wt; Meds; Lab; Eyes; XR.

F/U: Routine 90 days: _____ Other 4 wks

Problem List Updated: Yes No

Plasencia

Physician/NP/PA

Marshall, Carl

NAME

MALE

GENDER

B/W

RACE

110574

AIS#

8/6/50

DOB

IMMUNIZATION RECORD

Name Marshall, Carl AIS 110574 D.O.B. 8-6-50

Hep A Vaccine

Date _____ By _____

Date _____ By _____

Hep B Vaccine

1) Date _____ By _____

2) Date _____ By _____

3) Date _____ By _____

Influenza

Date <u>11/2/06</u>	By <u>supervisor</u>	Date _____	By _____
Date _____	By _____	Date _____	By _____
Date _____	By _____	Date _____	By _____
Date _____	By _____	Date _____	By _____
Date _____	By _____	Date _____	By _____
Date _____	By _____	Date _____	By _____

Pneumococcal

Date _____	By _____	Date _____	By _____
Date _____	By _____	Date _____	By _____

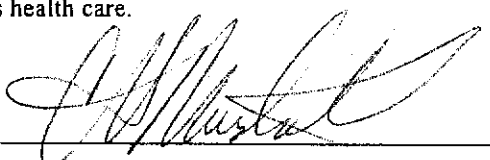
TB PPD

Date <u>4/24/06</u>	Result <u>0mm</u>	Date _____	Result _____
Date _____	Result _____	Date _____	Result _____
Date _____	Result _____	Date _____	Result _____
Date _____	Result _____	Date _____	Result _____
Date _____	Result _____	Date _____	Result _____
Date _____	Result _____	Date _____	Result _____
Date _____	Result _____	Date _____	Result _____
Date _____	Result _____	Date _____	Result _____

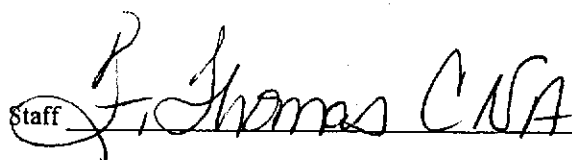
Tetanus Date _____ By _____

Tetanus Date _____ By _____

I have read the *access to health care* information sheets and have been given a copy. I understand how to access health care.

Name  Date 04/23/06

AIS# 110574

Medical Staff  P. Thomas CNA Date 4-25-06

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

RECEPTION MENTAL HEALTH SCREENING EVALUATION

Institution: Kilby Date/Time Inmate Received: 4/21/06
Date/Time of Screening: 4/21/06 Signature/Title of Screener: DMC Reddy

MENTAL HEALTH TREATMENT PRIOR TO ENTERING THE ADOC:

Yes ☒ No ☐ Psychotropic medication: _____
Yes ☒ No ☐ Medication turned over to ADOC upon arrival? _____
Yes ☒ No ☐ Mental health follow-up in last 90 days: _____
Yes ☒ No ☐ Suicide/self-harm attempts in last 90 days: _____

MENTAL HEALTH HISTORY Does inmate report a history of the following (if yes, provide details):

Yes ☒ No ☐ Outpatient treatment: _____
Yes ☒ No ☐ Inpatient treatment: _____
Yes ☒ No ☐ Psychotropic medication: _____
Yes ☒ No ☐ Suicidal attempts: _____
Yes ☒ No ☐ Suicidal thoughts: _____
Yes ☒ No ☐ Head injury: _____
Yes ☒ No ☐ Seizures: _____
Yes ☒ No ☐ Violent behavior: _____
☒ Yes ☒ No ☐ Substance abuse: _____
Yes ☒ No ☐ Substance abuse treatment: _____
Yes ☒ No ☐ Special education classes: _____

INMATE SELF-REPORT OF CURRENT STATUS:

Yes ☒ No ☐ First incarceration (reaction): 3rd "OKing"
☒ Yes ☒ No ☐ Reports family support: Brother, Mother
Yes ☒ No ☐ Reports significant depression/remorse: _____
Yes ☒ No ☐ Thinking about suicide: _____
Yes ☒ No ☐ Has plan for suicide: _____
Yes ☒ No ☐ Possible to implement suicide plan: _____
Yes ☒ No ☐ Reports hallucinations: _____

BEHAVIORAL OBSERVATIONS:

Poor eye contact	Poor hygiene	Unable to pay attention	Unresponsive
Disoriented	Anxious	Unable to follow directions	Unable to read
Crying	Memory deficits	Signs of self-mutilation	Afraid
Illogical speech content	Appears to be hearing voices or seeing things	Paranoid	
Hostile	Other unusual behavior: _____		

DISPOSITION/PLACEMENT RECOMMENDATION (based on reception mental health screening):

Routine housing	Emergency mental health referral
Mental health follow-up but not emergency	Crisis cell placement recommended
Current psychotropic meds verified	Interim supply ordered

Inmate Name: <u>Marshall, Carl</u>	AIS #: <u>110 574</u>
------------------------------------	-----------------------

Disposition: Inmate Medical Record

Reference: ADOC AR: 610, 612, 635
ADOC Form MH-011 - November 14, 2005

ALABAMA DEPARTMENT OF CORRECTIONS
INMATE ORIENTATION TO MENTAL HEALTH SERVICES

The Alabama Department of Corrections provides the following mental health services:

- Assessment and treatment of mental illness
- Referral to a psychiatrist, if necessary for medication
- On-going psychiatric treatment
- Group and individual counseling
- Assistance in dealing with stressful problems (adjustment to prisons, grief and loss, family problems)
- Crisis intervention
- Residential mental health treatment and hospitalization, if necessary

If you wish to speak with mental health staff about routine matters such as scheduling for group or individual counseling, send in a Health Services Request form.

In emergency situations or if you have concerns that need to be addressed immediately, contact any correctional officer so that you may receive mental health assistance as soon as possible.

Your participation in mental health services is voluntary except in emergency situations or when you have been provided due process through administrative review.

If you believe the mental health services provided to you are inadequate, you may file an inmate grievance.

Information about the mental health services provided to you is confidential except in the situations when mental health staff believe that you may be:

- Suicidal
- Homicidal
- Presenting a clear danger of injury to self or others
- Presenting a reasonable clear risk of escape or creation of institutional disorder
- Receiving Psychotropic medication
- Requiring movement to a special unit or cell for observation and treatment
- Requiring transfer to a psychiatric hospital outside of the prison
- Requiring a new program assignment for mental health reasons

Mental health staff has a legal duty to report to appropriate authorities any unreported suspected abuse or neglect of a child.

Mental health and medical staff will have access your mental health records when completing their duties. The following persons may have access to your mental health records on a need to know basis:

- Warden of the institution or designee
- Internal investigation staff and legal counsel working with the ADOC
- Departmental and accrediting audit staff
- Persons authorized by a court order or judgment

All other persons or agencies require an authorization for release of information signed by you before gaining access to your mental health records.

This information on this form has been explained to me and I have received a copy of the information for my future reference.


Inmate Signature

Marshal, Carl

110574C
AIS #

4/21/06
Date Signed



SPECIAL NEEDS COMMUNICATION FORM

Date: 7-10-7

To: DOL

From: HCU

Inmate Name: Marshall, Carl ID#: 110574

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

BS ✓ twice ~~wk~~ daily

BP ✓ twice wk

Date: 7-10-7 MD Signature: [Signature] Time: 1:40

Date 8/31/6

AIS # 110574

- ### **Briefly Outline Your Request - Then Drop In Mail Box**

Do Not Write Below This Line - For Reply Only

Collect Call

() Legal Officer - Notary () Record Office

Public



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Curt Marshall Date of Request: 7/6/06
 ID # _____ Date of Birth: _____ Location: _____
 Nature of problem or request: NEED Diabetic Shoes, due
Swelling of foot. & Callous on R & L foot
& Plaster to R heel. Will not wear Special Shoe
to WORK. Will continue but will take off

Signature _____

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

<p>RECEIVED</p> <p>Date: _____</p> <p>Time: _____</p> <p>Receiving Nurse Initials _____</p>

(S)ubjective: My foot swell & hurt everyday. I got
plaster on them.

(O)bjective Noted Callouses to R & L foot &
plaster to R heel. Has Magnetic socks.

(A)ssessment: Calloused feet. pt is diabetic

(P)lan: Refer to OPC
per JH

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



SPECIAL NEEDS COMMUNICATION FORM

Date: 9/11/06
To: REHF - ADOC
From: PHS/ADOC
Inmate Name: Marshall, Carl ID#: 110574

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

May have diabetic white tennis shoes & socks

Date: 9/11/06 MD Signature: [Signature] Time: 4:30 PM



SPECIAL NEEDS COMMUNICATION FORM

Date: 9/11/06
To: REF - ADOC
From: PHS/ADOC
Inmate Name: Marshall, Carl ID#: 110574

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

May have diabetic white tennis
shoes & socks

Date: 9/11/06 MD Signature: B. Adams Time: 1:30 PM



RENT

Kilby

I.D. #

D.O.B.:

BS ✓ BID x 30 days

[illegible]

Date	Initials	Signatures

Date	Initials	Signatures

**PRISON
HEALTH
SERVICES
INCORPORATED**

INSTRUCTIONS:

BLOOD PRESSURE RECORD

BP vs Sat, Sun, Mon, then Tue & Thurs

22 23 24

PHYSICIAN: _____

[illegible][illegible]

NAME:

Marshall, Carl
110574

LOCATION:



SPECIAL NEEDS COMMUNICATION FORM

Date: 9/8/06To: DOCFrom: OPCInmate Name: Marshall, Carl ID#: 110574

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

PATIENT may have diabetic shoes ifApproved by ADOCBS vs twice a day for 30 daysDate: 9/8/06 MD Signature: W.B. Adams MD/PH Time: Shawes, MD



PHYSICIANS' ORDERS

NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Last Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Fourth Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Third Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Second Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: MARshall, Carl 110574	DIAGNOSIS 1 Glucotrol 10mg BID 2 BS BID & Hemo 40 CRP Mayhoad / Bha 3 Hold work
D.O.B. 10 148	
ALLERGIES: Cyclin / clonidine	
Use First Date 8/27/07	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED

MEDICAL RECORDS COPY



PRISON
HEALTH
SERVICES
INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 7/26/07

To: PRF - ADOC

From: APs

Inmate Name: Marshall, Carl ID#: 110524

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra tray until see pm MD @ doc @ 11/12/07
5. Other _____

Comments:

Extra food tray & hypoglycemic BS 450.

Date: 7/26/07 MD Signature: Stankovich / Slane Time: 7:30 pm

Facility Name:		Month/Year of Charting:																																																
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30																				
Pneumovax Vaccine																																																		
Start Date: 7-10-7		Prescriber: myhard CRNP																																																
Stop Date:		RX #:																																																
↑ Lisinopril to 40mg ÷ PO BID X90																																																		
Start Date: 7-10-7		Prescriber: myhard CRNP																																																
Stop Date: 9-10-7		RX #:																																																
Feasol 325mg ÷ PO qd X90																																																		
Start Date: 7-10-7		Prescriber: myhard CRNP																																																
Stop Date: 9-10-7		RX #:																																																
Colace 100mg ÷ PO BID PRN X90																																																		
Start Date: 7-10-7		Prescriber: myhard CRNP																																																
Stop Date: 9-10-7		RX #:																																																
Start Date:		Prescriber:																																																
Stop Date:		RX #:																																																
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Stop Date:		RX #:																																																
Start Date:		Prescriber:																																																
Stop Date:		RX #:																																																
Diagnosis	Nurse's Signature										Initial										Nurse's Signature										Initial										Documentation Codes									
Allergies																																									1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show									
Housing Unit:																																																		
Patient ID Number:																																																		
Patient Name:																																																		



PHYSICIANS' ORDERS

NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Last Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Marshall, Carl	DIAGNOSIS (If Chg'd)
D.O.B. 8/6/48 110574	12/ Pneumonia vaccine
ALLERGIES: Tetracycline Chlorine	
Use Fourth Date 7/10/07 7-10-07	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Marshall, Carl	DIAGNOSIS (If Chg'd)
D.O.B. 8/6/48 110544	1/ Urine microalbumin 1 year
ALLERGIES: Tetracycline Chlorine	2/ 2000 cal ADA diet x 90 days
Use Third Date 7/1/07	3/ No add'l salt diet x 90 days
	4/ Ang II dilate peripheral arteries
	5/ Not death for cancer (Plasma Dutty)
	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Marshall, Carl	DIAGNOSIS (If Chg'd)
D.O.B. 8/6/48 110574	1/ T Lisinopril to 40mg PO BID x 90 days
ALLERGIES: Tetracycline Chlorine	2/ ECASA 325mg PO QD x 90 days
Use Second Date 7/10/07	3/ Colace 100mg PO BID PRN x 90 days
	4/ DR #1, HgbA1C
	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Marshall, Carl	DIAGNOSIS
110574 3/17/07 0939	1) Glucosyl 10mg po qd x 180d
D.O.B. 08/06/50	2) T Colan SE 240mg po qd x 180d
ALLERGIES: Tetracycline Chlorine	3) HgbA1c in 10 weeks
Use First Date 3/10/07	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED

DIABETES CLINIC

Q 3-months

Name: Mars 5/9/11 ^{card} DOB: 5-6-48 AIS#: 110574 R/S BM

PATIENT HISTORY

1) HTN
 2) DM II
 Diagnosis: Type I Type II Date of Diagnosis: 4-26-06
 Current Meds: Glucotrol 10mg qd, Calan SR 240mg qd, Lisinapril 20mg qd
 Diet/Exercise: NO Occ. Compliant: Y (N)
 Frequency of BG monitoring: once daily
 Risk factors (check all that apply)
 Family History: Smoker HTN Obesity CAD Hyperlipidemia Renal Disease Tobacco use
T. 9.24 3.47 9.74 BS 145

VARIABLE	Date <u>7-10-7/1350</u>	Date	Date
BP/Weight/Pulse	<u>135/100 250 81</u>		
CP/dizziness/Indigestion	<u>0/0/0</u>		
Exertional Dyspnea	<u>0</u>		
Urinary frequency	<u>0</u>		
Fundi exam (annually)	<u>out 7/10/07</u>		
Dental exam (annually)	<u>out 7/10/07</u>		
Hand and Foot pain	<u>0/0</u>		
General Appearance	<u>NAD, ND, NN</u>		
Heart	<u>S1S2 2nd/3rd/4th c</u>		
JVD/Carotid Bruits	<u>5cm Q45</u>		
Periph. Pulses/edema	<u>+2 PP/P T</u>		
Microfilament (annually)	<u>See with 7/10/07</u>		

LABS	Date	Date	Date
Fasting Diagnostic	<u>2/2/07</u>		
Profile II (base line)	<u>TC 186 HDL 36</u>		
Hgb A1c q 3-6 mos	<u>2/2/07</u>		
BMP (per MD/NP)	<u>2/2/07</u>		
UA Dipstick	<u>out 7/10/07</u>		
Microalb (annually)	<u>4/2/06 7/10/07</u>		
EKG (base line)	<u>4/2/06</u>		
Disease Control	<u>Good/Fair/Poor</u>	<u>Good/Fair/Poor</u>	<u>Good/Fair/Poor</u>
	<u>Improved/Worsened</u>	<u>Improved/Worsened</u>	<u>Improved/Worsened</u>

PLAN

Flu vac (annually)	<u>206</u>		
Pneumovax	<u>out 7/10/07</u>		
Patient Edu/Training	<u>DM II, HTN</u>		
Completed Master Problem Sheet	<u>yes</u>		
Next F/U	<u>2nd Flu shot</u>		
Signature	<u>[Signature]</u>		

SHORT TERM GOALS	LONG TERM GOALS
1 <u>Rev DM II</u>	1 <u>pt CAD</u>
2 <u>Rev Urine microalbum</u>	2 <u>HbA1c ~ 5.5-6.0</u>

3 Rev A1c
 4) Control blood pressure
 5) LDL goal < 100
 6) BP < 130/80



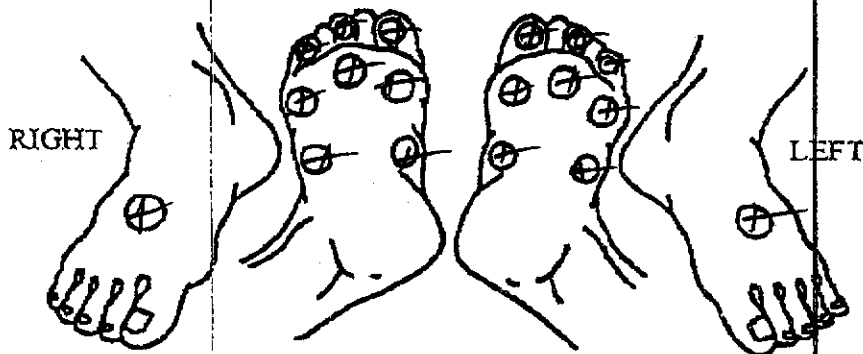
PRISON
HEALTH
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MONOFILAMENT TESTING FOR DIABETICS

Fill in the following blanks with a "Y" or "N" to indicate findings

	RIGHT	LEFT
Is there a foot ulcer now?	N	N
Is there a history of foot ulcer?	N	N
Is there an abnormal shape of the foot?	N	N
Is there a toe deformity?	N	N
Are the toenails thick or ingrown?	Y	Y
Is there callus buildup?	N	N
Is there swelling?	N	N
Is there elevated skin temperature?	N	N
Is there muscle weakness?	N	N
Can the inmate see the bottom of feet?	Y	Y
Is the inmate wearing improperly fitting shoes?	N	N
Does the inmate use footwear appropriate?	Y	Y
Pulses? DP/PT	+2 DP/PT	+2 DP/PT

Note the level of sensation in the circles: (+) → Can feel the 5.07 filament (-) → Can't feel the 5.07 filament



Skin Conditions on the Foot or Between the Toes:

Draw in: Callous , Pre-ulcer , Ulcer  (note length and width in cm)
 Label with: R - Redness, M - Maceration, D - Dryness, T - Tinea

Risk Category:

<input checked="" type="checkbox"/>	0 No loss of protective sensation.
<input type="checkbox"/>	1 Loss of protective sensation
<input type="checkbox"/>	2 Loss of protective sensation with <u>either</u> high pressure (callous/deformity), or poor circulation.
<input type="checkbox"/>	3 History of plantar ulceration, neuropathic fracture (Charcot foot) or amputation.

Education done about on foot care Education Received by pt

Name <u>Mandell, Carl</u>	AMS NO <u>110574</u>	Date <u>7/6/07</u>	By <u>M. Cray</u>
------------------------------	-------------------------	-----------------------	----------------------

INMATE NAME Marshall, Carl AIS # 110574

[illegible]

PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

Date: 3/7/07 Time: _____ Facility: Kilby Correctional FacilityCheck all applicable CIC's being evaluated: Card/HTN DM GI ID PUL SZ TBSUBJECTIVE:OBJECTIVE: BP 180/110 HR 50 RR 18 Temp 99 Wt 247 Peak Flow _____

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT, Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

- 1) DM
- 2) HTN

No. 90.
 Compliance questionable
 Labs 2/07 ok. Chol 400, H. C 9.4.
 (+) smoking → decreased
 lungs clear. Heart MMR I (M).
 Edema, hirsute.

Glucosol 5mg p.o. QD
 Calan SR 180mg p.o. QD
 Lisinopril 20mg p.o. BID
 EC ASA 325mg p.o. QD

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
 Status: I=Improved, S=Stable, W=Worsened

DM	HTN/CARD	SZ	PUL	ID	GI	OTHER
Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control
G (F) P	G (F) P	G F P	G F P	G F P	G F P	G F P
Status	Status	Status	Status	Status	Status	Status
I (S) W	I (S) W	I S W	I S W	I S W	I S W	I S W

PLAN: 1) ↑ Calan 2) ✓ H. C next visit.
 2) ↑ Glucosol

F/U: Routine 90 days: ☒ Other _____ Problem List Updated: Yes No



Physician/NP/PA

Marshall Cecil
 NAME

male
 GENDER

(B) / W
 RACE

110574
 AIS#
8/6/50
 DOB

DEPARTMENT OF CORRECTIONS
NURSE'S
CV/HTN CHRONIC CARE CLINIC

S: CHRONIC CARE CLINIC				ALLERGIES	
DATE/TIME 3/7/07 @ 0850				Telemetry done, Clonidine	
O: VS T99 P90 R15 WT247				HX a treadmill? Y (N)	
BP 180/110 IF BP > 140/90 REFER TO MD/NP/PA				Date:	
Do you smoke?		<input checked="" type="radio"/> Y	<input type="radio"/> N	HX bypass surgery: Y (N)	
Use salt?		<input type="radio"/> Y	<input checked="" type="radio"/> N	Date:	
Family History of CVHTN? Entire Family		<input checked="" type="radio"/> Y	<input type="radio"/> N		
Obese?		<input type="radio"/> Y	<input checked="" type="radio"/> N		
Stress?		<input type="radio"/> Y	<input checked="" type="radio"/> N		
Blurred vision		<input type="radio"/> Y	<input checked="" type="radio"/> N		
Headache		<input type="radio"/> Y	<input checked="" type="radio"/> N		
Fatigue		<input type="radio"/> Y	<input checked="" type="radio"/> N		
Muscle weakness		<input type="radio"/> Y	<input checked="" type="radio"/> N		
Polyuria		<input type="radio"/> Y	<input checked="" type="radio"/> N		
Epistaxis		<input type="radio"/> Y	<input checked="" type="radio"/> N		
S.O.B.		<input type="radio"/> Y	<input checked="" type="radio"/> N	P: LABS REVIEWED	
Compliant with meds		<input type="radio"/> Y	<input checked="" type="radio"/> N	Labs ordered	
KOP		<input type="radio"/> Y	<input checked="" type="radio"/> N	Last CMP-14 2/24/07	
Counseled on risk factors Non-Modifiable		<input type="radio"/> Y	<input checked="" type="radio"/> N	Last EKG 4/28/04	
Describe: Race ② Age ③ Gender ④ Heredity					
MODIFIABLE ① Smoking cessation					
① Wt. Reduction ③ Activity ④ Diet ⑤ Fat					
Labs/EKG WNL		NA			
CXR if over 50		<input type="radio"/> Y <input checked="" type="radio"/> N			
Education Done S.O.B. NOISE		<input type="radio"/> Y <input checked="" type="radio"/> N			
Symptoms: light-headedness, weakness, numbness, tingling, tightness of chest, confusion, face, arm					
Topic: S/S of Stroke VS. heart attack (1 side)					
Recently admitted to hospital/infirmery		<input type="radio"/> Y	<input checked="" type="radio"/> N	CURRENT MEDICATIONS:	
Notes: 4 BP readings addressed		Clon SR 180 mg po. QD			
continue to HTN teachings & plan		Lisinopril 20 mg po. BID			
Encourage compliance to med		EC ASA 325 mg po. QD			
diet + exercise to ↓ risk of stroke					
heart attack + blindness					
		Status: (circle) 1st/120			
		IMPROVED UNCHANGED WORSENER			
		Level of Control: (circle)			
		GOOD FAIR POOR			
		CCC WITH NURSE (circle)			
		1, 2, ③ Months			
		CCC WITH MD (circle)			
		1, 2, ③ 4, 5, 6 Months			
INMATE NAME		NUMBER	AGE	RACE/SEX	SIGNATURE
Marshall, Carl		110374	56	B/M	[Signature]

Control Good---BP < 140/90
Fair----BP 140-160/90/100
Poor----BP > 160/100

Status: Improved---BP < previous visit
Unchanged---BP unchanged
Worsened---BP increased,

PRISON
HEALTH
SERVICES
HOSPITAL

DEPARTMENT OF CORRECTIONS

NURSE'S

DIABETIC CHRONIC CARE CLINICS

S: DAY CHRONIC CARE CLINIC		ALLERGIES	
DATE/TIME: 7/1/07 @ 0855		tetracycline, Clonidine	
O: VS T 97 P 80 R 18			
BP 150/110 WT 247			
Any reactions:	Y	N	
Thirst, vomiting, or abdominal pain	Y	N	
Skin or foot problems:	Y	N	
Foot exam done:	Y	N	
Rotation of injection sites	N/A	Y	N
Changes in eyes	Y	N	
Dietary compliance:	Y	N	
Noncompliant---Education done	Y	N	P: LABS
Medication compliant	Y	N	
Noncompliant---Education done	Y	N	Last HgbA1C:
Tremors	Y	N	Date 2/20/07 Result 9.4
Reviewed canteen list	Y	N	
Compliant	Y	N	
If noncompliant, education done	Y	N	
Infirmity or hospital since last CCC visit	Y	N	
If yes, date	Y	N	ORDERS:
Review of FLU vaccine	Y	N	
Review of Pneumovax	Y	N	
Fundoscopic exam	Y	N	
Annual Diabetic Checklist updated	Y	N	
NOTES:			MEDICATION:
1n 3 mg A1C level in V to 10.5			Glucotrol 5 mg
87% of in rate will continue to			p.o. QD
be compliant make diet &			
EXERCISE			
			Status: (circle) 7-8
			Improved, Unchanged,
			Worsened
			Control: (circle)
			Good, Fair, Poor
			CCC NURSE (circle)
			EVERY 1, 2, 3 months
			CCC WITH MD (circle)
			1, 2, 3, 4, 5, 6 months
Education done ASOLKS BP			
EXERCISE, Nails straighten			
Topic FOOT CARE			
INMATE NAME	NUMBER	AGE	RACE/SEX
max shall, Gail	110574	56	B/M
Control Good High A1C WNL			
Fair High A1C within 2% of normal			
Poor High A1C 2% above normal			
Status Improved--Decrease in HgbA1C and weight			
Unchanged--No change in HgbA1C and weight			
Worsened--Increase in HgbA1C and weight			

60518-AI

PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

BEHF

Date: 12/11/06 Time: _____ Facility: Kilby Correctional FacilityCheck all applicable CIC's being evaluated: Card/HTN DM GI ID PUL SZ TBSUBJECTIVE:OBJECTIVE: BP 180/120 HR 84 RR 18 Temp 98 Wt 247 Peak Flow _____

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ

Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds,

Cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT,

Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

- 1) HTN
- 2) DM

no ch. glucose 1150
not taking BP meds bid (dizziness)
No recent labs.
lungs few @ rhonchi. Heart
RAA 5 @. @ edema, bruits

Glucotrol 5 mg p.o. QD
Calc SR 180 mg p.o. QD
Lisinopril 20 mg p.o. BID
EC ASA 325 mg p.o. QD

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
Status: I=Improved, S=Stable, W=Worsened

DM	HTN/CARD	SZ	PUL	ID	GI	OTHER
Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control
<u>G</u> F P	<u>G</u> F P	G F P	G F P	G F P	G F P	G F P
Status	Status	Status	Status	Status	Status	Status
I <u>S</u> W	I <u>S</u> W	I S W	I S W	I S W	I S W	I S W

PLAN: 1) Complaints
2) check labs next visit.

F/U: Routine 90 days: ✓ Other _____ Problem List Updated: Yes No

R.H.

Physician/NP/PA

Marshall, Carl

NAME

male

GENDER

B W

RACE

110574

AIS#

8-6-50

DOB

DEPARTMENT OF CORRECTIONS

NURSE'S

DIABETIC CHRONIC CARE CLINICS

S: DAY CHRONIC CARE CLINIC				ALLERGIES Tetracycline Clonidine	
DATE/TIME: 12/11/06 @ 0830					
O: VS T96 P84 R18					
BP 100/120 WT 247.50 lbs					
Any reactions:		Y	N	TYPE I	TYPE II
Thirst, vomiting, or abdominal pain		Y	N		
Skin or foot problems:		Y	N		
Foot exam done:		Y	N		
Rotation of injection sites		(N/A)	N		
Changes in eyes		Y	N		
Dietary compliance:		Y	N		
Noncompliant---Education done		Y	N	P: LABS	
Medication compliant		Y	N		
Noncompliant---Education done		Y	N	Last HgbA1C:	
Tremors		Y	N	Date 4/24/06	Result 7.8%
Reviewed canteen list		Y	N		
Compliant		Y	N		
If noncompliant, education done		Y	N		
Infirmary or hospital since last CCC visit		Y	N		
If yes, date		Y	N	ORDERS:	
Review of FLU vaccine		Y	N		
Review of Pneumovax		Y	N		
Fundoscopic exam		Y	N		
Annual Diabetic Checklist updated		Y	N		
NOTES:				MEDICATION:	
Educ. material given				Glucotrol 5mg po qd	
In 3 mos A1C goal will be				EC ASA 325 po qd	
L770 + in meal will continue					
to be compliant to diet, med					
+ Exercise					
				Status: (circle)	
				Improved, Unchanged,	
				Worsened	
				Control: (circle)	
				Good, Fair, Poor	
				CCC NURSE (circle)	
				EVERY 1, 2, 3 months	
				CCC WITH MD (circle)	
				1, 2, 3, 4, 5, 6 months	
Education done					
EXERCISE made straight aerobics					
Topic FOOT CARE					
INMATE NAME		NUMBER	AGE	RACE/SEX	SIGNATURE
Marshall, Carl	110574	56	BIA		

Control Good HgbA1C WNI
Fair HgbA1C within 2% of normal
Poor HgbA1C > 2% above normal

Status Improved: Decrease in HgbA1C and weight decrease by 5%
Unchanged: No change in HgbA1C and weight
Worsened: Increase in HgbA1C and weight

DEPARTMENT OF CORRECTIONS

NURSE'S

CV/HTN CHRONIC CARE CLINIC

S: CHRONIC CARE CLINIC

DATE/TIME 12/11/06 @ 0830

O: VS T99 P84 R18 WT 247.50 lbs

BP 180/120 IF BP > 140/90 REFER TO MD/NP/PA

Do you smoke?

Use salt?

Family History of CVHTN? Entire family

Obese?

Stress?

Blurred vision

Headache

Fatigue

Muscle weakness

Polyuria

Epistaxis

S.O.B.

Compliant with meds

KOP

Counseled on risk factors

Describe:

Non-modifiable

Race - A.A.

Age - 47 years

Labs/EKG WNL

CXR if over 50

Education Done

Topic: SS of Stroke

Recently admitted to hospital/infirmery

Notes:

MD discussed med

Ex 3 mos. BP reading will be

@ least 140/90 + in med

will be compliant c medRx

Exercise

ALLERGIES

Penicillin
Chlorine

HX a treadmill? Y (N)

Date:

HX bypass surgery: Y (N)

Date:

P: LABS REVIEWED

Labs ordered

Last CMP-14 4/26/06

Last EKG 4/26/06

CURRENT MEDICATIONS:

Calcium SR 180 mg p.o. BID

Lisinopril 20 mg p.o. BID

Status: (circle)

IMPROVED UNCHANGED WORSENER

Level of Control: (circle)

GOOD FAIR POOR

CCC WITH NURSE (circle)

1, 2, 3 months

CCC WITH MD (circle)

1, 2, 3, 4, 5, 6 Months

INMATE NAME

Marshall, Carl

NUMBER

110574

AGE

50

RACE/SEX

BIA

SIGNATURE:

[Signature]

Control

Good---BP < 140/90

Fair----BP 140-160/90/100

Poor----BP > 160/100

Status:

Improved---BP < previous visit

Unchanged---BP unchanged

Worsened---BP increased



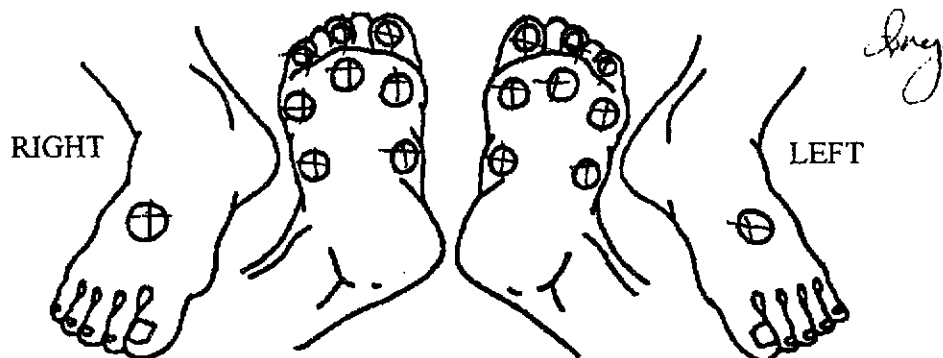
PRISON
HEALTH
SERVICES
INCORPORATED

MONOFILAMENT TESTING FOR DIABETICS




Fill in the following blanks with a "Y" or "N" to indicate findings

	RIGHT	LEFT
Is there a foot ulcer now?	n	n
Is there a history of foot ulcer?	n	n
Is there an abnormal shape of the foot?	n	n
Is there a toe deformity?	n	n
Are the toenails thick or ingrown?	n	n
Is there callus buildup?	n	n
Is there swelling?	n	n
Is there elevated skin temperature?	n	n
Is there muscle weakness?	n	n
Can the inmate see the bottom of feet?	X	X
Is the inmate wearing improperly fitting shoes?	X	X
Does the inmate use footwear appropriate?	X	X
Pulses? DP/PT	+2	+2

Note the level of sensation in the circles: (+) → Can feel the 5.07 filament (-) → Can't feel the 5.07 filament



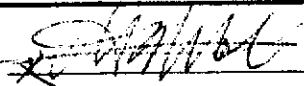
Skin Conditions on the Foot or Between the Toes:

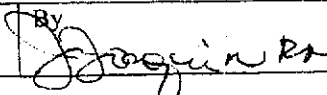
Draw in: Callous , Pre-ulcer , Ulcer  (note length and width in cm)
Label with: R - Redness, M - Maceration, D - Dryness, T - Tinea

Risk Category:

<input checked="" type="checkbox"/>	0 No loss of protective sensation.
<input type="checkbox"/>	1 Loss of protective sensation
<input type="checkbox"/>	2 Loss of protective sensation with <u>either</u> high pressure (callous/deformity), or poor circulation.
<input type="checkbox"/>	3 History of plantar ulceration, neuropathic fracture (Charcot foot) or amputation.

Education done about Foot care

Education Received 

Name <u>Marshall, Carl</u>	AMS NO <u>110574</u>	Date <u>12/11/06</u>	By <u></u>
-------------------------------	-------------------------	-------------------------	--

C A N T E E N S A L E S R F C E I P T

MARSHALL, CARL V. 110574 B/M 5/04/2006 3:37PM TRANS NR 88093

LI	ITEM NBR	ISSUE QTY	DESCRIPTION	UI	UNIT COST	EXTENDED COST
1	909	1	JUMBO CHILI CHSE DOG	EA	\$2.18	\$2.18
2	953	1	HORMEL M/W CHILI	EA	\$1.28	\$1.28
3	904	1	ICE CREAM	EA	\$1.30	\$1.30
4	904	1	ICE CREAM	EA	\$1.30	\$1.30
**** LAST ITEM ****						=====
TOTAL PURCHASES						\$6.06

OLD PMOD BALANCE 6.99 TOTAL PURCHASE 6.06 NEW PMOD BALANCE .93

TOTAL APPLIED TO WEEKLY LIMIT 12.01 POSTED BY: INMATE WORKERS

I CERTIFY THAT I RECEIVED ALL ITEMS AND QUANTITIES LISTED ABOVE.

SIGNATURE

DATE

BED NBR: M 086B

**PRISON
HEALTH
SERVICES
INCORPORATED**

NAME: Marshall, Carl

INSTITUTION/FACILITY: KILBY

CELL SITE:

I.D. # 110378

D.O.B.

PHYSICIAN ORDER/INSTRUCTIONS: BSV BID x 30c

[illegible]

Date	Initials	Signatures

Date	Initials	Signatures

KILBY CORRECTIONAL FACILITY

C A I T E E N S A L E S R E C E I P T

MARSHALL, CARL V. 110574 B/M 5/02/2006 3:35PM TRANS NR 87273

LI	ITEM NBR	ISSUE QTY	DESCRIPTION	UI	UNIT COST	EXTENDED COST
1	962	1	DR. PEPPER	EA	\$.52	\$.52
2	960	1	COKE	EA	\$.52	\$.52
3	924	2	MICROWAVE POPCORN	EA	\$.50	\$1.00
***** LAST ITEM *****						
TOTAL PURCHASES						\$2.04

OLD PMOD BALANCE 54.55 TOTAL PURCHASE 2.04 NEW PMOD BALANCE 52.51
TOTAL APPLIED TO WEEKLY LIMIT .00 POSTED BY: INMATE WORKERS

I CERTIFY THAT I RECEIVED ALL ITEMS AND QUANTITIES LISTED ABOVE.


SIGNATURE_____
DATE

BED NBR: M 086B

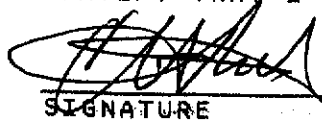
KILBY CORRECTIONAL FACILITY
C F T E E N S A L E S R C E I P T

MARSHALL, CARL V. 110574 B/M 5/02/2006 9:57AM TRANS NR 86956

LI	ITEM NBR	ISSUE QTY	DESCRIPTION	UI	UNIT COST	EXTENDED COST
1	960	2	COKE	EA	\$.52	\$1.04
2	912	1	DOUBLE CHEESE BURGER	EA	\$1.73	\$1.73
***** LAST ITEM *****						=====
TOTAL PURCHASES						\$2.77

OLD PMOD BALANCE 57.32 TOTAL PURCHASE 2.77 NEW PMOD BALANCE 54.55
 TOTAL APPLIED TO WEEKLY LIMIT .00 POSTED BY: INMATE WORKERS

I CERTIFY THAT I RECEIVED ALL ITEMS AND QUANTITIES LISTED ABOVE.



SIGNATURE

DATE

BED NBR: M 0868

K 3Y CORRECTIONAL FACILITY

C A N T E E N S A L E S R E C E I P T

MARSHALL, CARL V. 110574 B/M 5/03/2006 9:13AM TRANS NR 87476

LI	ITEM NBR	ISSUE QTY	DESCRIPTION	UI	UNIT COST	EXTENDED COST
1	140	1	REESE CUPS	EA	\$.57	\$.57
2	141	1	SNICKERS	EA	\$.57	\$.57
3	173	3	G/F CORN CHIPS	EA	\$.48	\$1.44
4	174	3	G/F CHEESE CURLS	EA	\$.42	\$1.26
5	183	1	TROPHY MIXED NUTS	EA	\$1.05	\$1.05

***** LAST ITEM *****

=====

TOTAL PURCHASES \$4.89

OLD PMOD BALANCE 13.44 TOTAL PURCHASE 4.89 NEW PMOD BALANCE 8.55

TOTAL APPLIED TO WEEKLY LIMIT 12.01 POSTED BY: PATTI P VERMILYER

I CERTIFY THAT I RECEIVED ALL ITEMS AND QUANTITIES LISTED ABOVE.


SIGNATURE_____
DATE

BED NBR: M 086B

KELF

12/06

Facility Name:

Glucotrol 5mg
P.O. BID X 180
days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:	12/11/06										Prescriber: Dr. Raffone																				
Stop Date:	6/11/07										RX #:																				

Calan SR 180mg
P.O. BID X 180 days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:	12/11/06										Prescriber: Dr. Raffone																				
Stop Date:	6/11/07										RX #:																				

Lisinopril 20mg
P.O. BID X 180 days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:	12/11/06										Prescriber: Dr. Raffone																				
Stop Date:	6/11/07										RX #:																				

EC ASA 325mg
P.O. BID X 180
days.

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:	12/11/06										Prescriber: Dr. Raffone																				
Stop Date:	6/11/07										RX #:																				

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:											Prescriber:																				
Stop Date:											RX #:																				

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:											Prescriber:																				
Stop Date:											RX #:																				

Diagnosis	Insurance Problem	Notes	Physician Signature	Order	Dispensation Codes
TCN, Clonidine					1. Dispensing Order 2. Refused 3. Patient Out of Facility 4. Changed in Error 5. Lost Order 6. Not Authorized 7. Manufacturer Out of Stock 8. Medication Expired 9. No Stock 10. Other
Housing Unit:					
Patient ID Number:					
Patient Name:					
Marshall, Carl					5/06/07

Facility Name: <u>REHF</u>		Month/Year of Charting: <u>7/07</u>																																																	
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																				
4 Glucotrol 10mg P.O. QD X180 days																																																			
	Start Date: <u>8/7/07</u>															Prescriber: <u>Dr. Robbins</u>																																			
	Stop Date: <u>9/3/07</u>															RX #:																																			
Calcium SR 240mg P.O. QD X180 days																																																			
	Start Date: <u>8/7/07</u>															Prescriber: <u>Dr. Robbins</u>																																			
	Stop Date: <u>8/7/07</u>															RX #:																																			
Lipitor 20mg P.O. BID X180 days																																																			
	Start Date: <u>12/7/07</u>															Prescriber: <u>Dr. Robbins</u>																																			
	Stop Date: <u>6/11/07</u>															RX #:																																			
EC ASA 325mg P.O. BID X180 days																																																			
	Start Date: <u>12/7/07</u>															Prescriber: <u>Dr. Robbins</u>																																			
	Stop Date: <u>6/11/07</u>															RX #:																																			
	Start Date:															Prescriber:																																			
	Stop Date:															RX #:																																			
	Start Date:															Prescriber:																																			
	Stop Date:															RX #:																																			
Diagnosis:		Nurse's Signature:										Initial:										Nurse's Signature:										Initial:										Documentation Codes									
Allergies:																																										1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lack Data 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Study 10. Other									
Housing Unit:																																																			
Patient ID Number:																																																			
Patient Name:																																																			
Marshall, Carl																																																			



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: Carl Marshall Date of Request: MAY 1, 2006
ID # 110574 Date of Birth: 8/6/50 Location: M-86

Nature of problem or request: BLOOD SUGAR HAS JUMPED
TO HIGH FROM 44 - 296 IN LESS
THAN 2 WKS

[Signature]
Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
Time: AM PM
Allergies:

<p align="center">RECEIVED</p> <p>Date: _____</p> <p>Time: _____</p> <p>Receiving Nurse Initials _____</p>

(S)ubjective:

Su Net

(O)bjective (V)S: T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()
Was MD/PA on call notified: Yes () No ()

5/16/06
60

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Nursing Evaluation Tool:

General Sick Call

Facility: KCF
 Patient Name: Marshall Carl
 Inmate Number: 110 574
 Date of Report: 5 4 06 MM DD YYYY
 Date of Birth: 8 4 50 MM DD YYYY
 Time Seen: 0640 AM/PM Circle One

Subjective: Chief Complaint(s): BS has been going ↑ too high
 Onset: _____

Brief History: S3 40 Bm c HR NIDPM, HTW
(Continue on back if necessary)

Objective: Vital Signs: (As Indicated) T: 98.6 P: 79 RR: 24 B/P: 199/105 Wgt 243.5
 Examination Findings: FSBS @ 7:15A 301
(Continue on back if necessary)

Assessment (Referral Status) Preliminary Determination(s): Aut. in conf. R/F
☐ Referral NOT REQUIRED
☒ Referral REQUIRED due to the following: alone statement
☐ Recurrent Complaint (More than 2 visits for the same complaint)
☒ Other: Uncontrolled BS

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

- ☐ Instructions to return if condition worsens.
☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)
☐ Other: _____

OTC Medications given ☒ NO ☐ YES (If Yes List): _____

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): B Adams CAMP

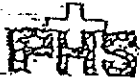
Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): _____

Date for referral: 5 4 06
MM DD YYYY
 Time: _____

Lorraine
 Nurse Signature

Name: Lorraine Graves
 Printed

178
104



Nursing Evaluation Tool:

General Sick Call

Facility: KCP
 Patient Name: Marshall, Carl
 Home Number: 110574
 Date of Report: 9-8-06
 Date of Birth: 8-6-50
 Time Seen: 6:00 (AM/PM Circle One)

Subjective: Chief Complaint(s): Ordered an order for my diabetic
shoes. Feet swells.
 Brief History: 58 y.o. Bm c Hx HTN, NIDDM, sarcoidosis

Objective: Vital Signs: (As Indicated) 98.9° 127 RR: 20 BP: 170/90
 Examination Findings: A00x3. Resp. Neg c Lungs NAD

Assessment: (Referral Status) Preliminary Determination(s): Alt in comfort R/T
☐ Referral NOT REQUIRED
☒ Referral REQUIRED due to the following: (Check all that apply)
☐ Recurrent Complaint same as 2 wks in the same complaint
☒ Other: Profile for shoes

Concept: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or the nature of the appropriate care to be given.

Plan: Check All That Apply:
☐ Instructions to return if condition worsens.
☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)
☐ Other:

OTC Medications given ☒ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, When/Where): B Adams CAMP

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (If emergent who was contacted?):

Date for referral: 9-8-06
 Time

L. Graves
 Referral Signature

Name: Lorraine Graves
 Print



DEPARTMENT OF CORRECTIONS TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record

Institution: _____

Date: _____ Time: _____ AM/PM

RECEIVED FROM:

Institution/Work Release Center/Free-World Hospital

RECEIVING MEDICAL STATUS

☐ Population☐ Infirmary☐ Isolation

RELEASED: Inmate/Health Record

Institution: KCFDate: 5/24/06 Time: _____ AM/PM

RELEASE FROM:

☐ Infirmary ☐ Segregation
☒ Population ☐ Mental Health
☐ Other _____

RELEASE TO:

☒ DOC ☐ Infirmary ☐ Mental Health

Institution/Work Release Center/Free-World Hospital

ALLERGIES:

Tetracycline, Clonidine

PHYSICAL EXAMINATION

Date of last exam: 4/21/06Chest X-Ray Date: _____ Result: OKPPD Reading 4/24/06

Classification: _____

Limitations: _____

LAB RESULTS -- LAST REPORT

Treatments Completed

CBC

Normal

Abnormal

Urinalysis

RPR4/25/06
4/25/06☐☒☐☐☐☒Wears Glasses/Contacts ☐Dental Prosthesis ☐Hearing Aide ☐Other Prosthesis ☐

YES

NO

☐☐☐☐☐☐☐☐

Receiving Nurse

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

HTN, DM

CURRENT MEDICATION -- DOSAGE AND FREQUENCY

Lisinopril 20mg PO QDGlucotrol 5mg PO QDSurfak 240mg PO QDEC ASA 325mg PO QDValerian 1000mg PO Bid Error

SCHEDULE FOR CHRONIC CARE CLINIC

DATE: _____ LAST CLINIC: _____

MEDICATIONS

☒ Sent w / inmate☐ Not sent w / inmate

X-RAY FILM

☒ Sent w / inmate☐ Not sent w / inmate

HEALTH RECORD

☒ Sent w / inmate☐ Not sent w / inmateReleased to: DOCDate: 5-30-06 Time: 1:30 AM/PM

MEDICATIONS

☐ Received☐ Not Received

X-RAY FILM

☐ Received☐ Not Received

HEALTH RECORD

☐ Received☐ Not Received

CHART REVIEWED

☒ YES☐ NO

Received by:

Signature of Receiving Nurse

Date: 5-30-06 Time: 1:30 AM/PM

FOLLOW UP CARE NEEDED

Date

Time

With Whom -- Location (Sending Nurse)

Date/Appt. Made w/Whom (Rec. Nurse)

☒ Medical☐ Dental☐ Mental HealthNURSING ASSESSMENT (SENDING NURSE)
(Noted from health record documentation)

	Yes	No
HISTORY		
Drug Use		<input checked="" type="checkbox"/>
Mental Illness		<input checked="" type="checkbox"/>
Suicide Attempt		<input checked="" type="checkbox"/>
Chronic Care		<input checked="" type="checkbox"/>

STATUS		
Special Diet		<input checked="" type="checkbox"/>
Appearance		

OTHER PERTINENT NURSING ASSESSMENT

NURSING ASSESSMENT (RECEIVING NURSE)
(Noted from inmate assessment)

	Yes	No
SKIN		
Open Sores		<input checked="" type="checkbox"/>
Lice		<input checked="" type="checkbox"/>
Edema		<input checked="" type="checkbox"/>
Warm & Dry	<input checked="" type="checkbox"/>	
Cool & Moist		

CONDITION		
Alert	<input checked="" type="checkbox"/>	
Oriented	<input checked="" type="checkbox"/>	
Uncooperative		<input checked="" type="checkbox"/>
Depressed		

INTAKE

Sick Call Procedures Explained OKHeight 6'3"Weight 225Blood Pressure 140/90Temperature 98.6Pulse Resp. 28/18

Other _____

Signature of Nurse Completing Assessment (Sending Nurse)

Date

Signature of Intake Screening Nurse (Receiving Nurse)

Date

INMATE NAME (LAST, FIRST, MIDDLE)

DOC#

DOB

Race/Sex

FAC

McCall, Carl V. 1105748-6-503m 1/16

PHS-MD-70009

(White - Medical Jacket, Yellow - Transfer Coordinator)



PHYSICIANS' ORDERS

NAME: Marshall, Carl 110574 514/06 915A noted D.O.B. 1/1 ALLERGIES: TCN, Clonidine Use Last Date 5/4/06	DIAGNOSIS (If Chg'd) ⑤ Surfak 240mg p.o. QD x 30d ① Clonidine error p.o. now ② Re - ✓ BP in + home ③ Increase Lisinopril to 20mg p.o. BID x 180d ④ Decrease Glucotrol to 5mg p.o. QD x 180d <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Marshall, Carl 110574 D.O.B. 8/6/50 ALLERGIES: Use Fourth Date 4/25/06	DIAGNOSIS (If Chg'd) Hypertension Colan SR 180mg po qd x 180 days <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Marshall, Carl 110574 D.O.B. 8/6/50 ALLERGIES: TCN, Clonidine Use Third Date 4/25/06	DIAGNOSIS (If Chg'd) Diabetic eye exam - DM Glucotrol 10mg po qd x 180 days Lisinopril 20mg po qd x 180 days ELASA 325mg po qd x 180 days CC 4 wks B/P & BS H/A <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Marshall, Carl 110574 D.O.B. 8/6/50 ALLERGIES: TCN, Clonidine Use Second Date 4/25/06	DIAGNOSIS (If Chg'd) 2200 Calorie DM diet + snack <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Marshall, Carl 110574 D.O.B. 8/6/50 ALLERGIES: Use First Date 4/25/06	DIAGNOSIS Cmp, Chg, PSA, Hgb A1c, TSH, UACR 4/25/06 EKG Cx eye referral B50 Bz 2300mg B/P v 2x wk x 4 wks <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED



PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
	Marshall, amir Carl	1 1
5/4/06 0850	Flu BS ✓'s . clo HTN. Requests stool softener. BP: 199/105 this A.M. BS ✓'s have been 44 - 296 mg/dL HybA1c - 7.9 - He has 9 documented BS ✓'s in the 40's & Δ in PE 1) HTN - Clonidine 0.1 mg now ^{error} / Re-✓ in 7 hours - Increase Lisinopril to 20 mg BID - BP ✓'s - CCC as sched. 2) NIDDM 2 episodes of hypoglycemia - Decrease Glucotrol to Sug QD - BS ✓'s - CCC as sched. 3) Acute Constipation (x findings on PE) - 9 fluids / fiber / exercise - Sulfak x 30d E: TX plan Blum	
5/5/06 0820	needs TX for ⊕ RPR x Bicillin LA avail. ; Allergic to TTC. x consulted to Dr. Robbins - E-mycin 1gm BID x 30d - medical hold	

Blum



PHYSICIANS' ORDERS

NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Last Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Fourth Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Third Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Marshall, Carl 110574	DIAGNOSIS (If Chg'd) 4/21/06
D.O.B. 8.6.50	Zantac 350mg P.O. BID X 5 days
ALLERGIES: Adalate, Tetracycline	Benadryl 25mg P.O. qid X 5 days
Use Second Date 4/21/06	Protocol / No Drugs /
	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Marshall, Carl 110574	DIAGNOSIS 15005 & B50
D.O.B. 8.6.50	- Metoprolol 100mg P.O. BID X 5 days
ALLERGIES: Adalate, Tetracycline, Clonidine	- Pifedural XL 60mg P.O. qid X 5 days
Use First Date 4/21/06	- Atenolol 50mg P.O. bid X 5 days
	- Guanipril 40mg P.O. qid X 5 days
	Protocol / No Drugs /
	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED

MEDICAL RECORDS COPY



60110 (4/03)



PHYSICIANS' ORDERS

NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Last Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Marshall, Carl	DIAGNOSIS (If Chg'd)
D.O.B. 8/6/98 110574	12/ Pneumonia vaccine
ALLERGIES: Tetracycline, Clonidine	
Use Fourth Date 7/10/07 7-10-07	<input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Marshall, Carl	DIAGNOSIS (If Chg'd)
D.O.B. 8/6/98 110574	6/ Urine microalbumin (1st day)
ALLERGIES: Tetracycline, Clonidine	7/ 2000 cal ADT diet x 90 days
Use Third Date 7/10/07	8/ No added salt diet x 90 days
	9/ And dilute phosphate cream (1st day)
	10/ 1000 cal diet for 90 days (Phos Diet)
	<input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Marshall, Carl	DIAGNOSIS (If Chg'd) B/D x Zink
D.O.B. 8/6/98 110574	1) T Lisinopril to 40 mg PO BID x 90 days
ALLERGIES: Tetracycline, Clonidine	2) ECASA 325 mg PO QD x 90 days
Use Second Date 7/10/07	3) Colace 100 mg PO BID x 90 days
	4) DP #1, HgbAK
	<input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Marshall, Carl	DIAGNOSIS
574 3/17/07 0939	1) Glucosyl 10 mg po qd x 180d
D.O.B. 08/06/98	2) T Colace SE 240 mg po qd x 180d
ALLERGIES: Tetracycline, Clonidine	3) HgbAK in 10 units
Use First Date 3/10/07	<input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED

Facility Name:		Month/Year of Charting:																																																	
Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																				
Pneumoc Vaccine																																																			
		Start Date: 7-10-7															Prescriber: mylord CRW																																		
		Stop Date:															RX #:																																		
↑ Lisinopril to 40mg - PO BID K90																																																			
		Start Date: 7-10-7															Prescriber: mylord CRW																																		
		Stop Date: 9-10-7															RX #:																																		
Feasa 325mg - PO qd K90																																																			
		Start Date: 7-10-7															Prescriber: mylord CRW																																		
		Stop Date: 9-10-7															RX #:																																		
Colace 100mg - PO BID PRN K90																																																			
		Start Date: 7-10-7															Prescriber: mylord CRW																																		
		Stop Date: 9-10-7															RX #:																																		
		Start Date:															Prescriber:																																		
		Stop Date:															RX #:																																		
		Start Date:															Prescriber:																																		
		Stop Date:															RX #:																																		
Diagnosis		Nurse's Signature										Initial										Nurse's Signature										Initial										Documentation Codes									
Allergies																																										1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lack of info 6. Staff Absent/Overdosed 7. Medication out of stock 8. Medication Held 9. No Show 10. Other									
Housing Unit:																																																			
Patient ID Number:																																																			
Patient Name:																																																			
Marshall C...																																																			



PRISON
HEALTH
SERVICES
INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 7/26/07
 To: PEP ADOC
 From: PHS
 Inmate Name: Marshall, Carl ID#: 110524

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra tray until see pm MD @ doc @ 1/1/08
5. Other _____

Comments:

Extra food tray if hypoglycemic BSK 50.

Date: 7/26/07 MD Signature: [Signature] Time: 7:30 pm



PHYSICIANS' ORDERS

NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Last Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Fourth Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Third Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Second Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: MARSHALL, Carl 110574	DIAGNOSIS D ↑ Glucotrol 10mg BID 2 BS BID. & started 40 CRP Maphad / <i>[Signature]</i> ③ Hold work <i>[Signature]</i>
D.O.B. 8 16 1948	
ALLERGIES: Cyclosporine / clonidine	
Use First Date 8 12 77	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED

MEDICAL RECORDS COPY

04/28/2006 9:21:14

ID: #STAT#060428092115

D.O.B.: 8/6/58

Meds:

Class:

Dr:

Tech:

Chad W. Marshall 11/25/74

56 6/2 Int-230

Vent. Rate:	71 bpm
RR Interval:	835 ms
PR Interval:	156 ms
QRS Duration:	90 ms
QT Interval:	384 ms
QTc Interval:	403 ms
QT Dispersion:	30 ms
P-R-T AXIS:	53° 13°-159°

SINUS RHYTHM

** INTERPRETATION MADE WITHOUT KNOWING PATIENT'S GENDER/AGE **

Abnormally high SV1 + RV5

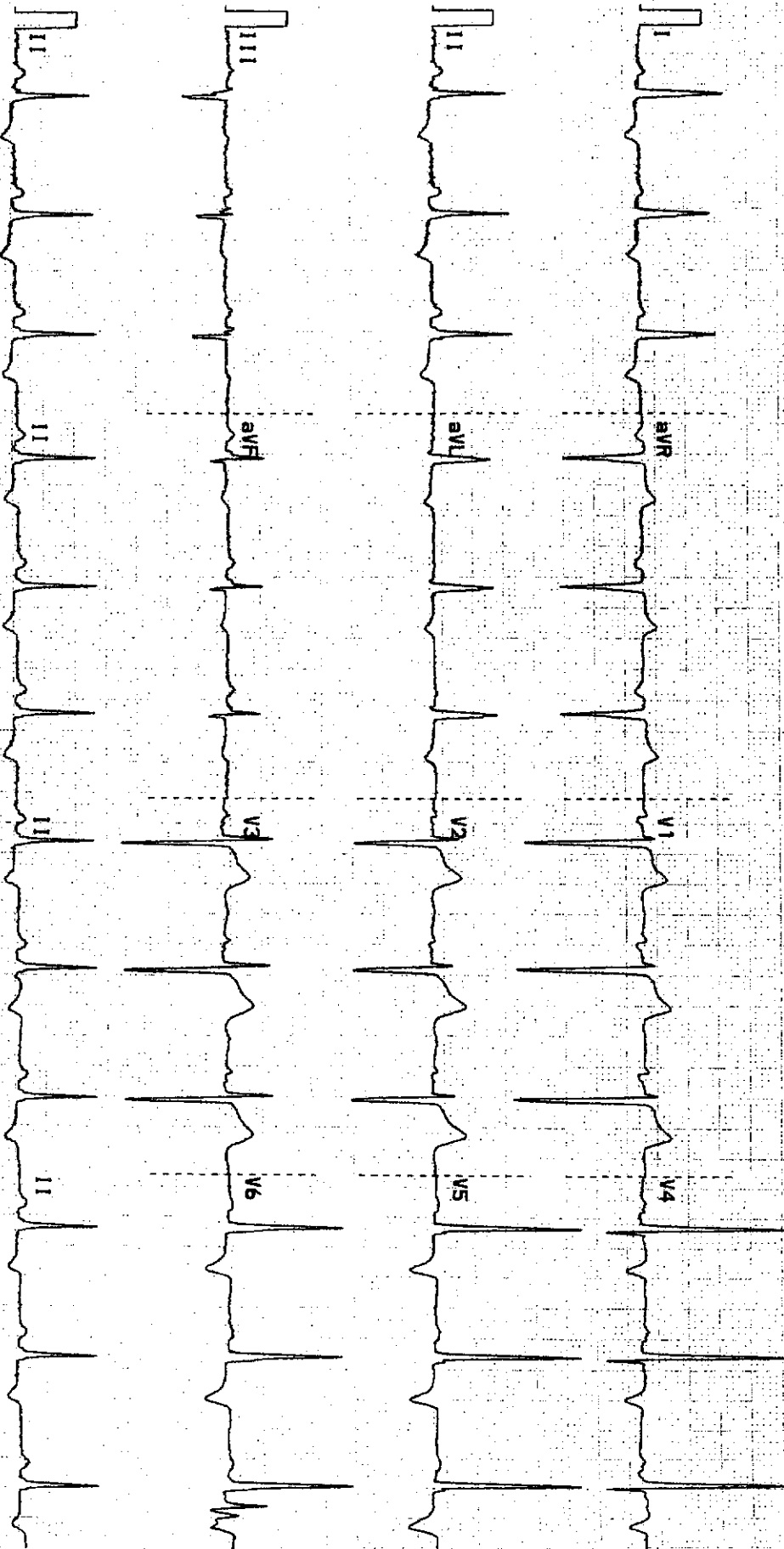
LVH WITH SECONDARY REPOLARIZATION ABNORMALITY

Extensive ST-T changes

THESE CHANGES ARE PROBABLY DUE TO VENTRICULAR HYPERTROPHY

Summary: ABNORMAL ECG

* Unconfirmed Analysis *

L: 10 mm/mV
C: 10 mm/mV

QTc=Hodges

Art. a 3000 Int. ref. 200002026 (0004)

Ser. a) 2. AS000 007143

25 mm/s
STABLE 150 Hz

SINUS RHYTHM
 ** INTERPRETATION MADE WITHOUT KNOWING PATIENT'S GENDER/AGE **
 Abnormally high SV1 + RV5
 LVH WITH SECONDARY REPOLARIZATION ABNORMALITY
 Extensive ST-T changes
 THESE CHANGES ARE PROBABLY DUE TO VENTRICULAR HYPERTROPHY

Summary: ABNORMAL ECG

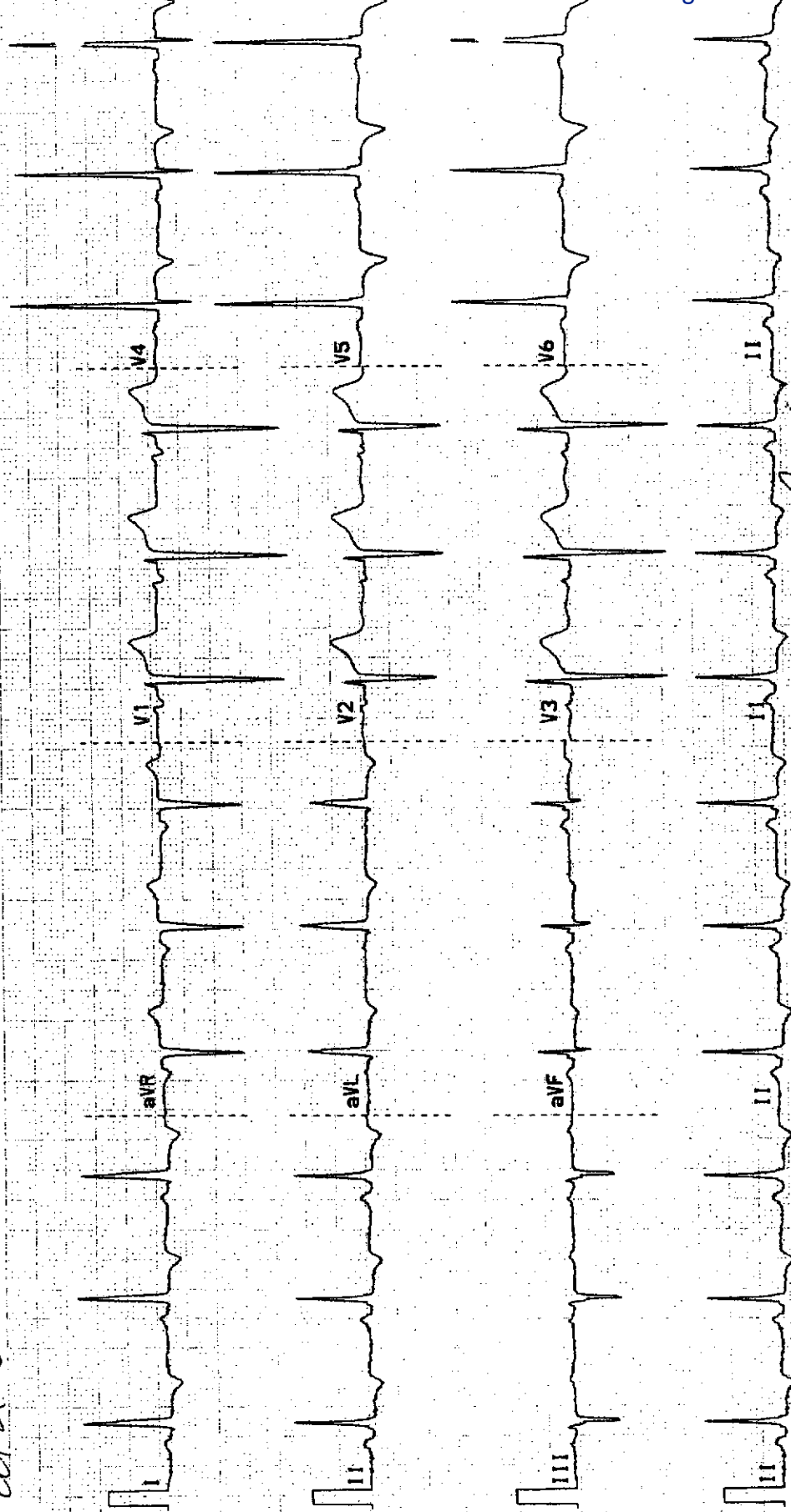
* Unconfirmed Analysis *

04/28/2006 9:21:34

ID: #STAT#060428092134

Vent. Rate:	72 bpm
RR Interval:	833 ms
PR Interval:	156 ms
QRS Duration:	90 ms
QT Interval:	400 ms
QTc Interval:	421 ms
QT Dispersion:	46 ms
P-R-T AXIS:	53° 13°-169°

Carl Marshall 110574
 56
 6/2 4/230



Carl Marshall 110574

25 mm/s
 STABLE 150 Hz

L: 10 mm/mV
 C: 10 mm/mV

qTc=Hodges

At: a 3000 Int ref (20060202AE 0001)

Serial #A3000 007713

50-22

[illegible]

FROM CAHABA IMAGING

(THU) APR 27 2006 14:53/ST. 1443/NO. 5312281257 P 16

RADIOLOGY SERVICES REQUEST AND REPORT

SUBS ID: 110574

DOB: 8-6-50

INSTITUTION:

KCF Marshall (PE)

Race: B Sex: M

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP

Date of request

Time of request

Routine

Priority

Transportation or special needs

Lassiter

4-25-6

HISTORY/DIAGNOSIS:

Protocol / DM / HTN

X-RAY REQUEST

ABDOMEN/KUB	FINGERS	NAVICULAR VIEW	FOOT TISSUE STUDIES
ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)	FOOT	ORBITS	STERNUM
ANKLE	HAND	OT CALCH (HEEL)	TEMPORO-MANDIBULAR JOINTS
CERVICAL SPINE	HIP	PELVIS	THORACIC SPINE
<input checked="" type="checkbox"/> CHEST PA / LATERAL	HUMERUS	RADIUS/ULNA	THLATHRULA
COCCYX	KNEE	RIBS	TOES
CONE DOWN SELLA TURCICA	LUMBAR SPINE	SACRO-ILIAC JOINTS	WRIST
ELBOW	MANDIBLE	SCAPULA	ZYGOMA
FACIAL BONES	MAXILLA	SHOULDER	ZYGOMATIC ARCH
FEMUR	NASAL BONES	SKULL	

REPORT

Carl Marshall

Marshall

Chest: The heart is not enlarged. The lungs are clear.

IMPRESSION: THERE IS NO EVIDENCE OF ACTIVE CARDIOPULMONARY DISEASE.

D: & T: 04-27-06 Thomas J. Payne, III, M.D./JH Board Certified Radiologist (Signature on file)

J5-126

X-RAY TECHNOLOGIST'S NAME (PRINT)

X-RAY TECHNOLOGIST'S SIGNATURE

DATE, TIME EXAM PERFORMED

RADIOLOGIST'S NAME (PRINT)

RADIOLOGIST'S SIGNATURE

DATE SIGNED



DEPARTMENT OF CORRECTIONS

DENTAL RECORD TREATMENT

Services Rendered[illegible]

PATIENT LAST NAME	FIRST	MIDDLE	DOB	R/S	ID NO.
-------------------	-------	--------	-----	-----	--------



DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES

DENTAL RECORD

DENTAL EXAMINATION	RESTORATIONS AND TREATMENTS
Date of Initial Examination <u>4-25-06</u>	Initial Classification

Oral Pathology Gingivitis
 Vincent's Infection
 Stomatitis
 Other Findings 89 - 6-11-06

Occlusion

Roentgenograms Periapical
 Bitewing
 Other

Health Questionnaire

YES	NO		YES	NO	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	V.D.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Allergy (Novocaine, penicillin, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Present Medication	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Anemia or Bleeding Problems
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Asthma	<input checked="" type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input checked="" type="checkbox"/>	HIV	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Other Disease

SERVICES RENDERED					
Date	Tooth #	DX	TX	Initials	Class
4-25-06	Em		OHT	JST	

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Marshall, Carl	110574	8-6-50	PO	KCF



**PRISON
HEALTH
SERVICES
INCORPORATION**

FINGER STICK BLOOD RECORD FORM

INSTITUTION/FACILITY: ELBA

I.D. # 110574 D.O.B.: 8/6/99

NAME: MARSHALL, CARL I.D. # 100579 D.O.B.: 8/27/70

CELL SITE: _____

PHYSICIAN ORDER/INSTRUCTIONS: _____

[illegible]

*Check if results called to physician.

[illegible]

Date	Initials	Signatures

ALABAMA DEPARTMENT OF CORRECTIONS

PROBLEM LIST

INMATE NAME Marshall, Carl AIS# 110574Medication Allergies: Tetracycline, ClonidineMedical: Chronic (Long-Term) Problems
Roman Numerals for Medical/SurgicalMental Health Code: SMI HARM HIST NONE
Capital Letter for Psychiatric Behavior

Date Identified	Chronic Medical Problem	Mental Health Code	Date Resolved	Provider Initials
4/25/06	HTN			st
4/25/06	DM			st
4/24/06	PPD <i>gmm</i>			st
11/2/06	<small>Aluminum Chloride TABLETS</small> LOT AFLUA210BA EXP. 06/30/07		11/2/06	cy

**If Asthmatic label: Mild – Moderate – or Severe.

KILBY CORRECTIONAL FACILITY
PO BOX 11
MT. MEIGS, AL 36057

DATE OF REPORT: 4/25/2006
TIME OF REPORT: 11:01 AM

ACCESSION NO. NPY8/110574	NAME CARL MARSHALL	FACILITY Kilby
-------------------------------------	------------------------------	--------------------------

DATE COLLECTED 4/25/06	TIME COLLECTED 8:30 AM	DATE RECEIVED 4/25/06	TIME RECEIVED 8:30 AM
----------------------------------	----------------------------------	---------------------------------	---------------------------------

Test Name	Result	Out of Range	Reference Range
HIV ANTIBODY	NEG		NEGATIVE (NEG)
RPR		R	NON-REACTIVE (NR)

URINALYSIS

PROTEIN	NEG		NEGATIVE (NEG)
GLUCOSE		POS 3+	NEGATIVE (NEG)
KETONES	NEG		NEGATIVE (NEG)
BILIRUBIN	NEG		NEGATIVE (NEG)
BLOOD	NEG		< 5 RBC/MCL (NEG)
NITRITE	NEG		NEGATIVE (NEG)
UROBILINOGEN	NEG		< 1.0 MG/DL (NEG)
LEUK. ESTERASE	NEG		NEGATIVE (NEG)

* NT = Not Tested



LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000



Phone: 205-581-3500

SPECIMEN TYPE PRIMARY LAB REPORT STATUS
116-205-5622-0 S MB COMPLETE Page #: 1

ADDITIONAL INFORMATION

PE8

4/25

FASTING: N
DOB: 8/06/1950

CLINICAL INFORMATION

CD- 41139330308

PATIENT NAME
MARSHALL, CARL
PT. ADD.:

SEX
M
AGE(YR./MOS.)
55 / 8

PHYSICIAN ID.
ROBBINS M
PATIENT ID.
110574

ACCOUNT: Kilby Correctional Facility
Prison Health Services
12201 Wares Ferry Road
Mt. Meigs AL 36507-0000

DATE OF COLLECTION TIME DATE RECEIVED DATE REPORTED TIME
4/26/2006 10:32 4/26/2006 4/27/2006 11:23 : 9836

ACCOUNT NUMBER: 01306900

TEST

RESULT

LIMITS

LAB

CMP14+LP+5AC

Chemistries

MB

> Glucose, Serum	128 H	mg/dL	65 - 99	MB
Uric Acid, Serum	6.0	mg/dL	2.4 - 8.2	MB
BUN	18	mg/dL	5 - 26	MB
Creatinine, Serum	1.0	mg/dL	0.5 - 1.5	MB
BUN/Creatinine Ratio	18		8 - 27	
Sodium, Serum	140	mmol/L	135 - 148	MB
Potassium, Serum	3.9	mmol/L	3.5 - 5.5	MB
Chloride, Serum	102	mmol/L	96 - 109	MB
Carbon Dioxide, Total	24	mmol/L	20 - 32	MB
Calcium, Serum	10.2	mg/dL	8.5 - 10.6	MB
Phosphorus, Serum	3.2	mg/dL	2.5 - 4.5	MB
Protein, Total, Serum	7.8	g/dL	6.0 - 8.5	MB
Albumin, Serum	4.3	g/dL	3.5 - 5.5	MB
Globulin, Total	3.5	g/dL	1.5 - 4.5	
A/G Ratio	1.2		1.1 - 2.5	
Bilirubin, Total	0.3	mg/dL	0.1 - 1.2	MB
Alkaline Phosphatase, Serum	58	IU/L	25 - 150	MB
LDH	175	IU/L	100 - 250	MB
AST (SGOT)	18	IU/L	0 - 40	MB
ALT (SGPT)	27	IU/L	0 - 55	MB
GGT	48	IU/L	0 - 65	MB
Iron, Serum	68	ug/dL	40 - 155	MB

Lipids

Cholesterol, Total	154	mg/dL	100 - 199	MB
> Triglycerides	251 H	mg/dL	0 - 149	MB
> HDL Cholesterol	33 L	mg/dL	40 - 59	MB
> VLDL Cholesterol Calc	50 H	mg/dL	5 - 40	
LDL Cholesterol Calc	71	mg/dL	0 - 99	
T. Chol/HDL Ratio	4.7	ratio units	0.0 - 5.0	
Estimated ChD Risk	0.9	times avg.	0.0 - 1.0	

T. Chol/HDL Ratio

Men Women

1/2 Avg. Risk	3.4	3.3
Avg. Risk	5.0	4.4
2X Avg. Risk	9.6	7.1
3X Avg. Risk	23.4	11.0

Pat Name: MARSHALL, CARL

Pat ID: 110574

Spec #: 116-205-5622-0

Seq #: 9836

Results are Flagged in Accordance with Age Dependent Reference Ranges

Continued on Next Page





LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000

Phone: 205-581-3500



SPECIMEN TYPE PRIMARY LAB REPORT STATUS
116-205-5622-0 S MB COMPLETE Page #: 2

ADDITIONAL INFORMATION

PI#8

4/25

FASTING: N
DOB: 8/06/1950

CLINICAL INFORMATION

CD- 41139330308

PATIENT NAME
MARSHALL, CARL
PT. ADD.:

SEX AGE(YR./MOS.)
M 55 / 8

PHYSICIAN ID. PATIENT ID.
ROBBINS M 110574

ACCOUNT: Kilby Correctional Facility
Prison Health Services
12201 Wares Ferry Road
Mt Meigs AL 36507-0000

DATE OF COLLECTION TIME DATE RECEIVED DATE REPORTED TIME
4/26/2006 10:32 4/26/2006 4/27/2006 11:23 9836

ACCOUNT NUMBER: 01306900

TEST	RESULT	LIMITS	LAB
------	--------	--------	-----

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of premature CHD.

Microalb/Creat Ratio, Randm Ur

Creatinine, Urine	169.6	mg/dL	Not Estab.	MB
-------------------	-------	-------	------------	----

> Microalbum., U, Random	499.8H	ug/mL	0.0 - 17.0	MB
--------------------------	--------	-------	------------	----

> Microalb/Creat Ratio	294.7H	ug/mg creat	0.0 - 30.0	
------------------------	--------	-------------	------------	--

Hemoglobin A1c

> A1c	7.8H	%	4.5 - 5.7	MB
-------	------	---	-----------	----

Current guidelines recommend a treatment goal of <7% for diabetic patients. A1c may be overestimated in diabetic patients exhibiting poor control and who are also heterozygous or homozygous for HgbS or HgbC. Total glycohemoglobin is a better indicator of diabetic control in patients with these hemoglobin variants.

Prostate-Specific Ag, Serum

Prostate-Specific Ag, Serum	0.2	ng/mL	0.0 - 4.0	MB
-----------------------------	-----	-------	-----------	----

Beckman (formerly Hybritech) ICMA methodology

TSH	1.067	uIU/mL	0.350 - 5.500	MB
-----	-------	--------	---------------	----

LAB: MB LabCorp Birmingham

DIRECTOR: John Elgin N MD

1801 First Avenue South, Birmingham, AL 35233-0000

Pat Name: MARSHALL, CARL

Pat ID: 110574

Spec #: 116-205-5622-0

Seq #: 9836

Results are Flagged in Accordance with Age Dependent Reference Ranges
Last Page of Report



Bureau of Clinical Laboratories-Montgomery

PO BOX 244018, MONTGOMERY AL 36124-4018

Phone:(334) 260-3400 FAX:(334) 274-9800

Page: 1

Provider:

KILBY CORRECTIONAL FACILITY
P O BOX 150
MT MEIGS, AL, 36057-0000
(334) 215-6600,
MONTGOMERY CO HD

Accession

4022235
Requisition #: 4022235
Service Area:
CHR #:

ID:**1028940****Patient:****Marshall, Carl**

D.O.B.: 8/ 6/1950

Sex: M MALE

Phone: (000) 000-0000

Collected: 4/25/2006 @

Received: 4/26/2006 @ 8:27 AM

Reported: 5/ 1/2006 @ 3:31 PM

Status: Final Report

Test Name	Result	Units	Normal Range	Notes
-----------	--------	-------	--------------	-------

Serology Results

~ VDRL, STS Quantitative	Reactive 32 dils.	A
~ TP-PA Result	Reactive	A

Report Summary**Abnormal Summary**

~ VDRL, STS Quantitative	Reactive 32 dils.	A
~ TP-PA Result	Reactive	A

No treatment history ID TX finished 5/22/06 J

needs TX.
(P)

Lab Director

William J. Callan, Ph.D.

Date Printed: 5/ 1/2006 3:31 PM >> PH - Panic High > AH - Abnormal High ~ A - Abnormal *** Final Page ***
Completed Between: 4/27/2006 - 5/ 1/2006 << PL - Panic Low < AL - Abnormal Low δ Delta Check Failed All Results Included

Bureau of Clinical Laboratories-Montgomery

PO BOX 244018, MONTGOMERY AL 36124-4018

Phone:(334) 260-3400 FAX:(334) 274-9800

Page: 1

Provider:

KILBY CORRECTIONAL FACILITY
P O BOX 150
MT MEIGS, AL, 36057-0000
(334) 215-6600,
MONTGOMERY CO HD

Accession**4027103****ID:****1039432****Patient:****Marshall, Carl****Requisition #:****4027103****Service Area:****CHR #:****Collected: 6/ 2/2006 @****Received: 6/ 9/2006 @ 10:55 AM****Reported: 6/13/2006 @ 3:17 PM****D.O.B.: 8/ 6/1950****Sex: M MALE****Phone: (000) 000-0000****Status: Final Report****Test Name****Result****Units****Normal Range****Notes****Serology Results**

- VDRL, STS Quantitative **Reactive 32 dils.** A
- TP-PA Result **Reactive** A

Report Summary**Abnormal Summary**

- VDRL, STS Quantitative **Reactive 32 dils.** A
- TP-PA Result **Reactive** A

Lab Director**William J. Callan, Ph.D.**

Date Printed: 6/13/2006 3:17 PM >> PH - Panic High > AH - Abnormal High ~ A - Abnormal *** Final Page ***
 Completed Between: 6/12/2006 - 6/13/2006 << PL - Panic Low < AL - Abnormal Low 8 Delta Check Failed All Results Included

KILBY CORRECTIONAL FACILITY
PO BOX 11
MT. MEIGS, AL 36057

DATE OF REPORT: 6/7/2006
TIME OF REPORT: 11:25 AM

ACCESSION NO.	NAME	FACILITY
123/110574	CARL MARSHALL	REHF

DATE COLLECTED	TIME COLLECTED	DATE RECEIVED	TIME RECEIVED
6/2/06	8:30 AM	6/7/06	8:30 AM

Test Name	Result	Out of Range	Reference Range
HIV ANTIBODY	NT		NEGATIVE (NEG)
RPR		R	NON-REACTIVE (NR)
URINALYSIS			
PROTEIN	NT		NEGATIVE (NEG)
GLUCOSE	NT		NEGATIVE (NEG)
KETONES	NT		NEGATIVE (NEG)
BILIRUBIN	NT		NEGATIVE (NEG)
BLOOD	NT		< 5 RBC/MCL (NEG)
NITRITE	NT		NEGATIVE (NEG)
UROBILINOGEN	NT		< 1.0 MG/DL (NEG)
LEUK. ESTERASE	NT		NEGATIVE (NEG)

* NT = Not Tested



BioReference
LABORATORIES

D O C T O R	KILBY CORR. FACILITY 12201 WARES FERRY RD. MONTGOMERY, AL 36507		BOOK/CASE:	
	(A0110-0) Bio-Net Print		-FINAL- Original Report 02/22/2007	
NAME MARSHALL, CARL		PATIENT I.D. / ROOM NO. 110574.2959		DOCTOR / GROUP NAME ROBBINS, MICHAEL
LAB I.D. NO. 103762211	DATE COLLECTED 02/20/2007 08:49 AM	DATE RECEIVED 02/21/2007 10:06	DATE OF REPORT 3/7/2007 08:50	AGE 56 Y SEX M

Test Description	Result	Abnormal	Reference Range
------------------	--------	----------	-----------------

GFR (Glomerular Filtration Rate) calculation utilizes the MDRD formula (Modification of Diet in Renal Disease Study Group) and assumes a normal adult body surface area of 1.73. If the patient is African American multiply result reported by 1.21. (Ref. National Kidney Disease Educa. Program.)

***** Male/Female reference range: >60 mL/min/1.73 m2 *****

Note: A calculated GFR of <60 mL suggests chronic kidney disease, but only if found consistently over at least 3 months. A calculated result of <15 mL is consistent with renal failure.

-----* MISCELLANEOUS *-----

HGB. Alc(glycoHgb)

9.4 HI < 6.0%

HEMOGLOBIN Alc RANGES(%)

< 6.0%
< 7.0%
> 8.0%

GLUCOSE CONTROL INDEX

Non-Diabetic Level

Diabetic Control

Additional action suggested

Final Report

Page: 2

James Weisberger
James Weisberger, M.D.
LABORATORY DIRECTOR

481 EDWARD H. ROSS DR.
ELMWOOD PARK, NJ 07407
1-800-229-1ABS
1255 Rev 1/05



BioReference
LABORATORIES

D O C T O R	KILBY CORR. FACILITY 12201 WARES FERRY RD. MONTGOMERY, AL 36507		BOOK/CASE:	
	(A0110-0) Bio-Net Print		-FINAL- Original Report 02/22/2007	
NAME MARSHALL, CARL		PATIENT I.D. / ROOM NO. 110574.2959		DOCTOR / GROUP NAME ROBBINS, MICHAEL
LAB I.D. NO. 103762211		DATE COLLECTED 02/20/2007 08:49 AM	DATE RECEIVED 02/21/2007 10:06	DATE OF REPORT 3/7/2007 08:50
		AGE 56 Y	SEX M	

Test Description	Result	Abnormal	Reference Range
------------------	--------	----------	-----------------

Tests Ordered : HEMOGLOBIN A1C, DIAGNOSTIC PROFILE I, ,

-----* CHEMISTRY *-----

Total Protein	7.6		5.9-8.4	gm/dl
Albumin	4.1		3.2-5.2	gm/dl
Globulin	3.5		1.7-3.7	gm/dL
A/G Ratio	1.2		1.1-2.9	
Glucose		162 HI	70-109	mg/dL
Sodium	140		133-145	mmol/L
Potassium	4.3		3.3-5.3	mmol/L
Chloride	102		96-108	mmol/L
CO2	26		21-29	mmol/L
BUN	17		7-25	mg/dl
* Creatinine	1.1		0.6-1.3	mg/dl
BUN/Creat Ratio	15.5		10-28	
Calcium	9.9		8.4-10.4	mg/dl
Uric Acid	5.2		2.4-7.0	mg/dl
Iron	75		30-160	mcg/dl
Bilirubin, Total	0.2		0.1-1.0	mg/dl
LDH	162		94-250	u/l
Alk Phos	91		39-120	u/l
AST (SGOT)	16		< 37	u/l
Phosphorous	3.3		2.6-4.5	mg/dl
ALT (SGPT)	17		< 40	u/L
G-GTP	47		7-51	u/L
Cholesterol	186		< 200	mg/dl
Triglycerides		213 HI	< 151	mg/dl
HDL CHOL., DIRECT	36		>35	mg/dl
HDL as % of Cholesterol		19		%
Chol/HDL Ratio		5.17		
LDL/HDL Ratio	3		0-3.55	
LDL Cholesterol		108 HI	< 100	mg/dL

* GFR, Estimated = 73.44 mL/min/1.73m2

Continued on Next Page

Page: 1

James Weisberger
James Weisberger, M.D.
LABORATORY DIRECTOR

481 EDWARD H. ROSS DR.
ELMWOOD PARK, NJ 07407
1-800-229-LABS
4066 Rev 1/05

DM

Facility Name: <u>LCF</u>		Hour	1	2	3	4	5	6	7	8	9	10	11	12
Metformin 1000mg + p.o. BID x 5 days	0800	<div>Start Date: 4/21/06 Robbins</div> <div>Stop Date: 4/27/06</div>												
	0300	<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
Atenolol 50mg p.o. qd x 5 days	0300	<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
	0300	<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
Quinapril 40mg p.o. qd x 5 days	0300	<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
	0300	<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
Nitroglycerin XL 60mg p.o. qd x 5 days	0300	<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
	0300	<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
Has Meds Beclomethasone 1.25mg p.o. qhs x 5 days	0300	<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
	0300	<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
Zantac 150mg p.o. BID x 5 days	0300	<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
	0300	<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
Diagnosis		<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
Allergies		<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
Housing Unit		<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
Patient ID Number		<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												
Patient Name		<div>Start Date: 4/22/06 Robbins</div> <div>Stop Date: 4/26/06</div>												

Chardine
Admet, Tetracycline

Robbins

Marshall, Carl 110374

9/6/00

Facility Name:	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Calum SR 180mg + po. 80 X 180d.	0300																								
Start Date: 4/25/6	Stop Date: 10/26/6	<div>Prescription: Lasinter Cap</div> <div>Signature: [Signature]</div>																							
Milicetral 10mg po. 80 X 180d.	0300																								
Start Date: 4/25/6	Stop Date: 10/26/6	<div>Prescription: Lasinter</div> <div>Signature: [Signature]</div>																							
Lisingsul 20mg po. 80 X 180d.	0300																								
Start Date: 4/25/6	Stop Date: 10/26/6	<div>Prescription: Lasinter</div> <div>Signature: [Signature]</div>																							
ECA 325g 80 X 180d.	0300																								
Start Date: 4/25/6	Stop Date: 10/26/6	<div>Prescription: Lasinter</div> <div>Signature: [Signature]</div>																							
Diagnosis	<div>Signature: [Signature]</div> <div>Signature: [Signature]</div>																								
Allergies	<div>Petrocytomegaly</div> <div>Signature: [Signature]</div>																								
Housing Unit:																									
Patient ID Number:	110574																								
Patient Name:	Marshall, Carl																								

Facility Name: KLPY Month/Year of Charting: 5/06

Surfak 240mg po qd x 30d

Hour: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Start Date: 5/4/06 Prescriber: H. E.

Stop Date: 6/4/06 RX #:

E-mycin 1gm po BID x 30d

Hour: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Start Date: 5/5/06 Prescriber: H. E.

Stop Date: 6/5/06 RX #:

Diagnosis: Tetracycline, Clonidine

Housing Unit: 110574

Patient's Name: Marshall, Carl

Nurse's Signature: [Signature] Initial: [Initial]

Nurse's Signature: [Signature] Initial: [Initial]

Documentation Codes:

- 1 Discontinued Order
- 2 Refused
- 3 Patient out of facility
- 4 Charted in Error
- 5 Look Over
- 6 Self Administered
- 7 Medication out of Stock
- 8 Medication Held
- 9 No Show
- 10 Other

Dm

#1

S/L6

Facility Name: KCF	Hour: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	Start Date: 4/25/06	Prescription: Lasix
Calan SR 180mg	0300 AD 5/4/06	Stop Date: 10/26/06	
Glucotrol 10mg	0300 AD 5/4/06	Start Date: 4/25/06	Prescription: Lasix
po qo x 180d.		Stop Date: 10/26/06	
Lisinopril 20mg	0300 AD 5/4/06	Start Date: 4/25/06	Prescription: Lasix
po. qo x 180d.		Stop Date: 10/26/06	
ECASA 325mg	0300 AD 5/4/06	Start Date: 4/25/06	Prescription: Lasix
po qo x 180d.		Stop Date: 10/26/06	
Lisinopril 20mg	0900 AD 5/4/06	Start Date: 5/4/06	Prescription: Lasix
PO BID x 180d	1500 AD 5/4/06	Stop Date: 11/4/06	
Glucotrol 5mg po	0300 AD 5/4/06	Start Date: 5/4/06	Prescription: Lasix
QD x 180d		Stop Date: 11/4/06	
Diagnosis	Diabetes, htn, HT & Smith cov AD		
Allergies	Tetracycline, clonidine		
Housing Unit:			
Patient ID Number:	110574		
Patient Name:	Marshall, Carl		

Facility Name:		Month Year of Study																														
KIBY Bicillin LA 2.4 mu IM qWK x 3wks	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	<div> <div>Start Date: 5/8/06</div> <div>Prescriber: B. Adams CRNA</div> <div>Stop Date: 5/23/06</div> <div>Rx #:</div> </div>																															
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	<div> <div>Start Date:</div> <div>Prescriber:</div> <div>Stop Date:</div> <div>Rx #:</div> </div>																															
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	<div> <div>Start Date:</div> <div>Prescriber:</div> <div>Stop Date:</div> <div>Rx #:</div> </div>																															
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	<div> <div>Start Date:</div> <div>Prescriber:</div> <div>Stop Date:</div> <div>Rx #:</div> </div>																															
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	<div> <div>Start Date:</div> <div>Prescriber:</div> <div>Stop Date:</div> <div>Rx #:</div> </div>																															
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	<div> <div>Start Date:</div> <div>Prescriber:</div> <div>Stop Date:</div> <div>Rx #:</div> </div>																															
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	<div> <div>Start Date:</div> <div>Prescriber:</div> <div>Stop Date:</div> <div>Rx #:</div> </div>																															
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	<div> <div>Start Date:</div> <div>Prescriber:</div> <div>Stop Date:</div> <div>Rx #:</div> </div>																															
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	<div> <div>Start Date:</div> <div>Prescriber:</div> <div>Stop Date:</div> <div>Rx #:</div> </div>																															
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	<div> <div>Start Date:</div> <div>Prescriber:</div> <div>Stop Date:</div> <div>Rx #:</div> </div>																															
Diagnosis	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	<div> <div>Start Date:</div> <div>Prescriber:</div> <div>Stop Date:</div> <div>Rx #:</div> </div>																															
Allergies	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	<div> <div>Start Date:</div> <div>Prescriber:</div> <div>Stop Date:</div> <div>Rx #:</div> </div>																															
Housing Unit:	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	<div> <div>Start Date:</div> <div>Prescriber:</div> <div>Stop Date:</div> <div>Rx #:</div> </div>																															
Patient ID Number:	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	

Facility Name:	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31																												
Culan SR 180mg	0300																																																											
	Start Date:		4/23/06										Prescriber:		LASSITER																																													
	Stop Date:		10/26/06										RX #:																																															
Glucetrol 5mgm ÷ po qd x 180d	0300																																																											
	Start Date:		5/4/06										Prescriber:		LASSITER																																													
	Stop Date:		11/4/06										RX #:																																															
Lisinopril 20mg ÷ po Bid x 180d	0300																																																											
	1500																																																											
	Start Date:		5/4/06										Prescriber:		LASSITER																																													
EUA 325mg ÷ po qd x 180d	0300																																																											
	Start Date:		4/23/06										Prescriber:		LASSITER																																													
	Stop Date:		10/26/06										RX #:																																															
Sur Fak 240mg po qd x 30d	0300																																																											
	Start Date:		5/4/06										Prescriber:		LASSITER																																													
	Stop Date:		6/14/06										RX #:																																															
	Start Date:												Prescriber:																																															
	Stop Date:												RX #:																																															
	Start Date:												Prescriber:																																															
	Stop Date:												RX #:																																															
Diagnosis	Nurse's Signature										Initial										Nurse's Signature										Initial										Documentation Codes																			
Allergies	Tetracycline										N. Hughes										MA										D. Smith										MA										<ul style="list-style-type: none"> 1. Discontinued Order 2. Reversed 3. Patient out of facility 4. Chained in Error 5. Lost Dose 6. Self Administered 7. Medication out of Stock 8. Medication Used 9. No Stock 10. Expired 									
Housing Unit																																																												
Patient ID Number																																																												
Patient Name																																																												
Marshall, Carl																																																												

Facility Name: Kilby Correctional Facility

Month/Year of Charting: 06/06

Calan SR 180MG Tab CR 30.00

Take 1 tablet(s) by mouth daily

Start Date: 04-27-2006

Prescriber: Lassiter, L.

Stop Date: 10-23-2006

RX #: 251448650

Glucotrol 10MG Tab 30.00

Take 1 tablet(s) by mouth daily

Start Date: 04-27-2006

Prescriber: Lassiter, L.

Stop Date: 10-23-2006

RX #: 251448653

Lisinopril 20MG Tab 30.00

Take 1 tablet(s) by mouth daily

Start Date: 04-27-2006

Prescriber: Lassiter, L.

Stop Date: 10-23-2006

RX #: 251448658

Aspirin EC 325MG EC Tab 30.00

Take 1 tablet(s) by mouth daily

Start Date: 04-27-2006

Prescriber: Lassiter, L.

Stop Date: 10-23-2006

RX #: 251448660

Glucotrol 5mg
÷ po qd x 180d

Start Date: 5-4-06

Prescriber: LR

Stop Date: 11-4-06

RX #:

Surfak 240mg
po qd x 30d

Start Date: 5-4-06

Prescriber:

Stop Date: 6-4-06

RX #:

Diagnosis

Nurse's Signature

Initial

Nurse's Signature

Initial

Documentation Codes

Allergies

Housing Unit: Population

Patient ID Number: 110574

Patient Name

Marshall, Carl

State of Birth

1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

K BY CORRECTIONAL FACILITY
C A N T E E N S A L E S R E C E I P T

MARSHALL, CARL V. 110574 B/M 5/03/2006 9:12AM TRANS NR 87475

LI	ITEM NBR	ISSUE QTY	DESCRIPTION	UI	UNIT COST	EXTENDED COST
1	808	6	.39 STAMPS	EA	\$.39	\$2.34
2	700	20	BOOK MATCHES	EA	\$.02	\$.40
3	602	3	DORAL MENTHOL 100	EA	\$4.26	\$12.78
4	607	1	KOOL FILTER KING	EA	\$4.65	\$4.65
5	611	1	NEWPORT KING	EA	\$4.65	\$4.65
6	623	3	BUGLER TOBACCO	EA	\$1.08	\$3.24
7	626	3	TOP MENT CIG TOBACCO	EA	\$1.09	\$3.27
8	430	1	COAST SOAP (BATH)	EA	\$.92	\$.92
9	806	1	BIC CLEAR BARREL-BLK	EA	\$.75	\$.75
10	211	1	MARUCHAN CHICK SOUP	EA	\$.47	\$.47
11	212	1	MARUCHAN SHRIMP SOUP	EA	\$.47	\$.47
12	119	240	STARDROPS CANDY	EA	\$.01	\$2.40
13	131	1	THREE MUSKETEER	EA	\$.57	\$.57
14	134	1	HERSHEY PLAIN	EA	\$.57	\$.57
15	137	1	MILKY WAY	EA	\$.57	\$.57

**** LAST ITEM ****

TOTAL PURCHASES \$38.05

OLD PMOD BALANCE 51.49 TOTAL PURCHASE 38.05 NEW PMOD BALANCE 13.44
TOTAL APPLIED TO WEEKLY LIMIT 7.12 POSTED BY: PATTI P VERMILYER

I CERTIFY THAT I RECEIVED ALL ITEMS AND QUANTITIES LISTED ABOVE.

SIGNATURE

DATE

BED NBR: M 086B

KILBY CORRECTIONAL FACILITY

C A T E E N S A L E S R E E I P T

MARSHALL, CARL V. 110574 B/M 5/01/2006 3:52PM TRANS NR 86682

LI	ITEM NBR	ISSUE QTY	DESCRIPTION	UI	UNIT COST	EXTENDED COST
1	960	3	COKE	EA	\$.52	\$1.56
2	902	3	GOLDEN FLAKE BBQ	EA	\$.31	\$.93
3	924	2	MICROWAVE POPCORN	EA	\$.50	\$1.00
4	904	1	ICE CREAM	EA	\$1.30	\$1.30
**** LAST ITEM ****						=====
* TOTAL PURCHASES						\$4.79

OLD PMOD BALANCE 62.11 TOTAL PURCHASE 4.79 NEW PMOD BALANCE 57.32
TOTAL APPLIED TO WEEKLY LIMIT .00 POSTED BY: INMATE WORKERS

I CERTIFY THAT I RECEIVED ALL ITEMS AND QUANTITIES LISTED ABOVE.


SIGNATURE_____
DATE

BED NBR: M 086B



DIABETIC CHECKLIST

Name Marshall Cecil Number 110574 Period 4/06 to 4/07
Glucophage 500mg p.o. qd 3/7/07 Glucophage 500mg p.o. qd
EC 375 p.o. qd
 Medications: _____

Compliance: (Yes) No

If No, follow-up counseling done: Yes No Date _____

Enrolled in Chronic Care: (Yes) No

Monofilament Foot Exams Done: (Yes) No
 Foot Disorders Treated: Yes No
 Educational Material Given: (Yes) No
 Appropriate Diet Ordered: Yes No
 Regular Glucose Testing: Yes No
 HgbA1C done q 3 months: Yes No Every 6 months if stable
 Seen by dental at least annually: Yes No
 Urine tested annually for microalbumin Yes No
 Seen by Nurse: 12/1/06, 3/2/07
 Seen by MD: 2/1/07, 3/27/07

Annual dilated retinal exam _____ By _____
 Referral if necessary _____

Immunization:

Pneumococcus once and repeated after age 64, if more than 5 yrs. Yes No
 Influenza annually 11/2/06 Yes No

Annual physical exam by MD/NP Yes No Date _____

Individual treatment plan Yes No

Updated Yes No

Appropriate Diet Ordered: Yes No

ADOC notified: Yes No



**DIABETIC INTAKE SCREENING
FOR INTAKES THAT PRESENT WITH DIABETES
Referral to MD and Seen within 24 hrs of Intake**

NAME Marshall, Cecil Number 110574 Date 4/25/06

Diagnosed with diabetes? Yes No

If yes, then H & P by licensed health care provider with prescriptive authority.

If yes, date H & P completed _____ by _____

Random plasma glucose test results 179 Date 4/25/06

If level > 200, then second test within 48 hours

Repeat results 156 Date 4/25/06

If level < 200, record flagged for a fasting glucose plasma test upon arrival at first assigned institution.

History of fasting Blood Sugar? (Yes) No Results/Date Not avail

History or Frequency of:

Ketoacidosis	<u>(Yes)</u>	No	<u>x 4 since dt</u>
Hypoglycemia	<u>(Yes)</u>	No	<u>"most mornings"</u>
Hypoglycemia w/o awareness	<u>(Yes)</u>	No	<u>per. actually 2 x 2 site</u>
History of known complications	Yes	<u>(No)</u>	

Screening Laboratory Evaluation (at reception) All diabetic receive:

Test	Date	Results in MR	Reviewed
HgbA1c upon arrival			
HDL--Cholesterol *			
Triglycerides *			
Total Cholesterol *			
Urine for microalbumin #140050--24 hr urine			
UA for protein & ketones (onsite)			
Serum Creatinine *			
TSH (when indicated) *			
EKG (onsite)	<u>4-25-06</u>		
Fundoscopic Exam			
Peripheral Pulses			

* Diagnostic profile II-(048827)-Includes Chem 7, Ca++, LFT's, Lipid Panel, Fe, Phos, Total Protein, Uric acid, Globulin, Transeptidase, Thyroid Panel, CBC w/Diff

Determination of Diabetes ----circle one----Type I Type II

Initial Treatment Plan by MD.....YES NO

Refer to Chronic Care Clinic within 7 days of

Diabetic diet..... YES NO Informed ADOC YES NO

Education: Documented in medical record.....Date _____

Reviewed by _____ Date _____

Physician's Chronic Care Clinic

Date: 4/28/06 Time: 1230 Facility: Kilby Correctional Facility

Check all applicable CIC's being evaluated: ☒ Card/HTN ☒ DM ☐ GI ☐ ID ☐ PUL ☐ SZ ☐ TB

SUBJECTIVE: DM & HTN @ 12yo name @ x 4 dys (4:15 AM)
was on DM & HTN @ 1969, taking med @ that time. ① DCUA x 3, ② M.I x 2 (1997)

OBJECTIVE: BP 180/110 HR 68 RR 20 Temp 98.6 Wt 240 Peak Flow 7 SB6-156
 NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ
 Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds,
 Cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT,
 Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

mom, COA

Doc DM/HTN Diabys

40HTA, Dennis SOB, Visual disturbance, CP on other legs

S, S, reg 50, ① Brn H, ② BRS clay keep ead. ③ put. dial. edema

① Cigs

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
 Status: I=Improved, S=Stable, W=Worsened

DM	HTN/CARD	SZ	PUL	ID	GI	OTHER
Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control
G F P	G F P	G F P	G F P	G F P	G F P	G F P
Status	Status	Status	Status	Status	Status	Status
I S W	I S W	I S W	I S W	I S W	I S W	I S W

PLAN: Will place on Glucotrol, Calan^{XL} Lisinopril, ASA; 4u p BS/BP
Decrease Cigs; Wt; Neds EKG Labg Eyes C&R,

F/U: Routine 90 days: Other 4wks Problem List Updated: Yes No

Plasenta

Physician/NP/PA

Marshall, Carl
 NAME

MALE
 GENDER

B/W
 RACE

110574
 AIS#

8/6/50
 DOB

IMMUNIZATION RECORD

Name Marshall, Carl AIS 110574 D.O.B. 8-6-50

Hep A Vaccine

Date _____ By _____

Date _____ By _____

Hep B Vaccine

1) Date _____ By _____

2) Date _____ By _____

3) Date _____ By _____

Influenza

Date <u>11/2/06</u>	By <u>suprobist</u>	Date _____	By _____
Date _____	By _____	Date _____	By _____
Date _____	By _____	Date _____	By _____
Date _____	By _____	Date _____	By _____
Date _____	By _____	Date _____	By _____
Date _____	By _____	Date _____	By _____

Pneumococcal

Date _____	By _____	Date _____	By _____
Date _____	By _____	Date _____	By _____

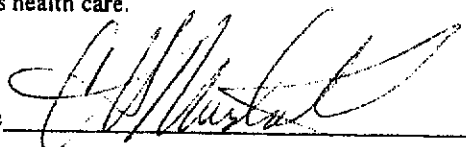
TB PPD

Date <u>4/24/06</u>	Result <u>0mm</u>	Date _____	Result _____
Date _____	Result _____	Date _____	Result _____
Date _____	Result _____	Date _____	Result _____
Date _____	Result _____	Date _____	Result _____
Date _____	Result _____	Date _____	Result _____
Date _____	Result _____	Date _____	Result _____
Date _____	Result _____	Date _____	Result _____
Date _____	Result _____	Date _____	Result _____

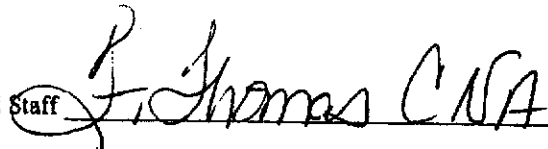
Tetanus Date _____ By _____

Tetanus Date _____ By _____

I have read the *access to health care* information sheets and have been given a copy. I understand how to access health care.

Name  Date 04/23/06

AIS# 110574

Medical Staff  P. Thomas CNA Date 4-25-06

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

RECEPTION MENTAL HEALTH SCREENING EVALUATION

Institution: Kilby Date/Time Inmate Received: 4/21/06
Date/Time of Screening: 4/21/06 Signature/Title of Screener: WMC Ready

MENTAL HEALTH TREATMENT PRIOR TO ENTERING THE ADOC:

Yes ☒ No ☐ Psychotropic medication: _____
Yes ☒ No ☐ Medication turned over to ADOC upon arrival? _____
Yes ☒ No ☐ Mental health follow-up in last 90 days: _____
Yes ☒ No ☐ Suicide/self-harm attempts in last 90 days: _____

MENTAL HEALTH HISTORY Does inmate report a history of the following (if yes, provide details):

Yes ☒ No ☐ Outpatient treatment: _____
Yes ☒ No ☐ Inpatient treatment: _____
Yes ☒ No ☐ Psychotropic medication: _____
Yes ☒ No ☐ Suicidal attempts: _____
Yes ☒ No ☐ Suicidal thoughts: _____
Yes ☒ No ☐ Head injury: _____
Yes ☒ No ☐ Seizures: _____
Yes ☒ No ☐ Violent behavior: _____
☒ Yes ☒ No ☐ Substance abuse: _____
Yes ☒ No ☐ Substance abuse treatment: _____
Yes ☒ No ☐ Special education classes: _____

INMATE SELF-REPORT OF CURRENT STATUS:

Yes ☒ No ☐ First incarceration (reaction): 3rd "OKing"
☒ Yes ☒ No ☐ Reports family support: Brother, Mother
Yes ☒ No ☐ Reports significant depression/remorse: _____
Yes ☒ No ☐ Thinking about suicide: _____
Yes ☒ No ☐ Has plan for suicide: _____
Yes ☒ No ☐ Possible to implement suicide plan: _____
Yes ☒ No ☐ Reports hallucinations: _____

BEHAVIORAL OBSERVATIONS:

Poor eye contact	Poor hygiene	Unable to pay attention	Unresponsive
Disoriented	Anxious	Unable to follow directions	Unable to read
Crying	Memory deficits	Signs of self-mutilation	Afraid
Illogical speech content	Appears to be hearing voices or seeing things	Other unusual behavior:	Paranoid
Hostile			

DISPOSITION/ PLACEMENT RECOMMENDATION (based on reception mental health screening):

Routine housing	Emergency mental health referral
Mental health follow-up but not emergency	Crisis cell placement recommended
Current psychotropic meds verified	Interim supply ordered

Inmate Name: Marshall, Carl AIS #: 110574

Disposition: Inmate Medical Record

Reference: ADOC AR: 610, 612, 635
ADOC Form MH-011 – November 14, 2005

ALABAMA DEPARTMENT OF CORRECTIONS
INMATE ORIENTATION TO MENTAL HEALTH SERVICES

The Alabama Department of Corrections provides the following mental health services:

- Assessment and treatment of mental illness
- Referral to a psychiatrist, if necessary for medication
- On-going psychiatric treatment
- Group and individual counseling
- Assistance in dealing with stressful problems (adjustment to prisons, grief and loss, family problems)
- Crisis intervention
- Residential mental health treatment and hospitalization, if necessary

If you wish to speak with mental health staff about routine matters such as scheduling for group or individual counseling, send in a Health Services Request form.

In emergency situations or if you have concerns that need to be addressed immediately, contact any correctional officer so that you may receive mental health assistance as soon as possible.

Your participation in mental health services is voluntary except in emergency situations or when you have been provided due process through administrative review.

If you believe the mental health services provided to you are inadequate, you may file an inmate grievance.

Information about the mental health services provided to you is confidential except in the situations when mental health staff believe that you may be:

- Suicidal
- Homicidal
- Presenting a clear danger of injury to self or others
- Presenting a reasonable clear risk of escape or creation of institutional disorder
- Receiving Psychotropic medication
- Requiring movement to a special unit or cell for observation and treatment
- Requiring transfer to a psychiatric hospital outside of the prison
- Requiring a new program assignment for mental health reasons

Mental health staff has a legal duty to report to appropriate authorities any unreported suspected abuse or neglect of a child.

Mental health and medical staff will have access your mental health records when completing their duties. The following persons may have access to your mental health records on a need to know basis:

- Warden of the institution or designee
- Internal investigation staff and legal counsel working with the ADOC
- Departmental and accrediting audit staff
- Persons authorized by a court order or judgment

All other persons or agencies require an authorization for release of information signed by you before gaining access to your mental health records.

This information on this form has been explained to me and I have received a copy of the information for my future reference.


Inmate Signature

Marshal, Carl

110574C
AIS #

4/21/06
Date Signed



SPECIAL NEEDS COMMUNICATION FORM

Date: 7-10-7

To: DOL

From: HCU

Inmate Name: Marshall, Carl ID#: 110574

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

BS ✓ twice ~~wk~~ daily
BP ✓ twice wk

Date: 7-10-7 MD Signature: [Signature] Time: 1:40

INMATE REQUEST SLIP

Name Carl Marshall Quarters A-6A Date 8/3/16
 AIS # 110574

() Telephone Call () Custody Change () Personal Problem
 () Special Visit () Time Sheet () Other MEDICAL

Briefly Outline Your Request - Then Drop In Mail Box

REQUEST THAT I SEE THE HEAD
STAFF NURSE, IN AN EFFORT TO
RECEIVE MUCH NEEDED SHOES IN
PERSONAL PROPERTY, DUE TO FEET
SWELLING AS A RESULT OF DIABETES
NURSE MUST APPROVE THEM,
AS PER CAPT. WOMBLE.
THANKING YOU IN ADVANCE

Do Not Write Below This Line - For Reply Only

Approved Denied Pay Phone Collect Call

Request Directed To: (Check One)

() Warden () Deputy Warden () Captain
 () Classification Supervisor () Legal Officer - Notary () Record Office
 Public



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Carl Marshall Date of Request: 7/6/06
 ID # _____ Date of Birth: _____ Location: _____
 Nature of problem or request: MEET Diabetic Shoes, due
Swelling of feet. & callous on R & L foot
& plaster to R heel. Will not wear special shoe
to work. Will continue but will take off

Signature _____

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

RECEIVED	
Date:	_____
Time:	_____
Receiving Nurse Initials	_____

(S)ubjective: My feet swell & hurt everyday. I got
plaster on them.

(O)bjective Noted Calluses to R & L foot
plaster to R heel. Has magnetic socks.

(A)ssessment: Calloused feet. pt is diabetic

(P)lan: Refer to OPC
per JH

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



SPECIAL NEEDS COMMUNICATION FORM

Date:

9/11/06

To:

REHIF - ADOC

From:

PHS/ADOC

Inmate Name:

Marshall Carl

ID#:

110574

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

May have diabetic white tennis shoes & socks

Date:

9/11/06

MD Signature:

A handwritten signature in dark ink, appearing to read "B. Adams".

Time:

4:30 PM



SPECIAL NEEDS COMMUNICATION FORM

Date: 9/11/06
To: RETF - ADOC
From: PHS/ADOC
Inmate Name: Marshall, Carl ID#: 110574

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

May have diabetic white tennis shoes & socks

Date: 9/11/06 MD Signature: [Signature] Time: 4:30 PM



REMF

Kilby

I.D. # 1102TS

D.O.B.:

BSV B11 x 30d_y

*Check if results called to physician.

Date	Initials	Signatures

REHF

4/21/06

INSTRUCTIONS:

BLOOD PRESSURE RECORD

MPes Sat, Sun, Mon, Thru Tue & Thurs;
22 23 24

PHYSICIAN: _____

[illegible][illegible]

NAME:

Marshall, Lar 1
110574

LOCATION: _____



SPECIAL NEEDS COMMUNICATION FORM

Date: 9/8/06To: DOCFrom: OPCInmate Name: Marshall, Carl ID#: 110574

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

PATIENT may have diabetic shoes ifApproved by ADOCBS VS twice a day for 30 daysDate: 9/8/06 MD Signature: VO B. Adams RNPI Time: Shawes, W



SPECIAL NEEDS COMMUNICATION FORM

Date: 5/8/06To: DOCFrom: OPCInmate Name: Marshall, Carl ID#: 110574

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Report TO OPC on 5/15/06 +
5/22/06 AT 7:00AM for injection
MEDICAL Hold until 5/23/06

Date: 5/8/06 MD Signature: VU B. Adams CNP/ Time: _____
Graves, W



7 IDDM

FINGER STICK BLOOD RECORD FORM

NAME: Earl Marshall INSTITUTION/FACILITY: _____
 I.D. # 110279 D.O.B.: 8/6/50

CELL SITE: _____

PHYSICIAN ORDER/INSTRUCTIONS: _____

DATE	TIME	INITIALS	BLOOD SUGAR RESULTS	URINARY KETONE LEVEL (if required)	INITIALS	*	ACTIONS TAKEN/COMMENTS
4/21	1500	AK	114				Recheck - 169 - after dinner
4/22	0400	CS	101				
4/22	1500	AK	114				
4/23	1500	AK	114				Recheck - 140 after dinner
4/24	0400	AK	114				
4/24	1500	AK	52				
4/25	0400	AK	98				Recheck - 140 after dinner
4/26	0400	AK	98				
4/27	0400	AK	57	5/4/06			
4/27/06	1500	AK	56	150			
4/28	0400	AK	68				
4/28	1500	AK	109				
4/29	0400	AK	98				
4/30	1500	AK	146				Recheck - 269 @ 1545 - after dinner
5/1	1100	AK	68				
5/2	0400	AK	178				
5/3	0410	AK	219				
5/4	0400	AK	296				

*Check if results called to physician.

Date	Initials	Signatures

Date	Initials	Signatures



SPECIAL NEEDS COMMUNICATION FORM

Date: 4/21/06To: ADXXFrom: WwInmate Name: Marshall, CARL ID#: 110514

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Add ²² Sat, ²³ Sun, ²⁴ Mon

Blood Pressure ✓ for 4 wks & times
a week Tues + Thurs - On WW @ 0500

Blood Sugar ✓ x 3 deep, on WW @
0300

Date: 4/21/06 MD Signature: V/D DeRobbins / D. Blumstein Time: _____

RECEIVING SCREENING FORM

INMATE'S NAME: Marshall, Carl DATE: 4/21/06 TIME: 7:00AM
 DOB: 8-6-50 OFFICER: COT Hives INSTITUTION: KILBY

RECEIVING OFFICER'S VISUAL OPINION

	YES	NO
Is the inmate conscious?	<u>✓</u>	<u> </u>
Does the inmate have any obvious pain or bleeding or other symptoms suggesting the need for doctor's care?	<u> </u>	<u> </u>
Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care?	<u> </u>	<u> </u>
Any obvious fever, jaundice, or other evidence of infection which might spread through the institution?	<u> </u>	<u> </u>
Is the skin in poor condition or show signs of vermin or rashes?	<u> </u>	<u> </u>
Does the inmate appear to be under the influence of alcohol, or drugs?	<u> </u>	<u> </u>
Are there any signs of alcohol or drug withdrawal? (Extreme perspiration, shakes, nausea, pinpoint pupils, etc.)	<u> </u>	<u> </u>
Is the inmate making any verbal threats to staff or other inmates?	<u> </u>	<u> </u>
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?	<u> </u>	<u> </u>
Does the inmate have any obvious physical handicaps?	<u> </u>	<u> </u>

FOR THE OFFICER

Was the new inmate oriented on sick/dental call procedures?

This inmate was ✓ a. Released for normal processing
 b. Referred to health care unit
 c. Immediately sent to the health care unit.

COT Hives
 Officer's Signature

This form will be completed at receiving and will be filed in the inmate's medical jacket to comply with NCCH Standards.

MEDICATIONS		HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
NIFEDICAL XL 60 MG TABLET		11/15/06																																
PROCARDIA XL 60 MG TABLET		AM																																
TAKE 1 TABLET ONCE DAILY			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
ATENOLOL 50 MG TABLET		11/15/06																																
TENORMIN 50 MG TABLET		AM																																
TAKE 1 TABLET ONCE DAILY			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
QUINAPRIL HCL 40 MG TABLET		11/14/06																																
ACCUPRIL 40 MG TABLET		AM																																
TAKE 1 TABLET ONCE DAILY			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
METFORMIN HCL 1,000 MG TABLET		01/16/07																																
GLUCOPHAGE 1,000 MG TABLET		AM																																
TAKE 1 TABLET TWICE DAILY			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24								

STARTING FOR	04/01/06	THROUGH	04/30/06	PAGE	1 OF	1
Physician	NICHOLS, KEN			Telephone No.	Medical Record No.	
Alt. Physician	NICHOLS, KEN			Alt. Telephone		
Allergies				Rehabilitative Potential		

Diagnosis		Approved By Doctor: <i>K. Williams</i>					
Medicaid Number	Medicare Number	By:	Title:			Date:	
RESIDENT	MARSHALL, CARL	D.O.B.	Sex	Room	Patient Code	Admission Date	
		08/06/1953	M	3E	MARSCARL	00/00/00	

[illegible][illegible]

INITIALS	NURSE'S SIGNATURE	INITIALS	NURSE'S SIGNATURE	INITIALS	NURSE'S SIGNATURE
RB [Signature]	[Signature: R. Brunette]	[Signature: M]	[Signature: M]		

INSTRUCTIONS		INJECTION SITE CODES:					
INITIAL APPROPRIATE BOX WHEN MEDICATION OR TREATMENT IS GIVEN	1. RIGHT DORSAL GLUTEUS	5. RIGHT LATERAL THIGH	9. RIGHT UPPER ARM	13. UPPER BACK LEFT	17. TO RIGHT AND ABOVE LEVEL OF UMBILICUS		
CIRCLE INITIAL WHEN MEDICATION OR TREATMENT IS REFUSED	2. LEFT DORSAL GLUTEUS	6. LEFT LATERAL THIGH	10. LEFT UPPER ARM	14. UPPER BACK RIGHT	18. TO LEFT AND ABOVE LEVEL OF UMBILICUS		
INDICATE INJECTION SITE WITH APPROPRIATE CODE	3. RIGHT VENTRAL GLUTEUS	7. RIGHT DELTOID	11. RIGHT ANTERIOR THIGH	15. UPPER CHEST LEFT	19. TO RIGHT AND BELOW LEVEL OF UMBILICUS		
STATE REASON FOR REFUSAL UNDER MEDICATION NOTES	4. LEFT VENTRAL GLUTEUS	8. LEFT DELTOID	12. LEFT ANTERIOR THIGH	16. UPPER CHEST RIGHT	20. TO LEFT AND BELOW LEVEL OF UMBILICUS		
STATE REASON AND RESULT FOR PRN MEDICATION OR TREATMENT							

INTAKE HEALTH EVALUATION

NAME: Marshall, CarlAIS #: 112574D.O.B.: 8-6-50

R.N. evaluation within 24 hours.

Age: 56 Sex: M Race: B Height: 6'2" Weight: 240Temp: 98.6 B/P: 180/100 Pulse: 68 Resp: 20

** B/P - If greater than 140/90, repeat in 1 hour. Refer to Mid-Level if B/P remains up.

Do you now or have you ever had, or been treated for:

78B5-156

Problem	Y	N	Problem	Y	N	Problem	Y	N
Head Trauma		✓	Gastritis <u>Hernia</u>		✓	HIV/AIDS ***		✓
Loss of Consciousness		✓	Ulcers		✓	***Medications Verified		✓
Severe Headaches		✓	Bleeding		✓	Hepatitis - Type		✓
Vertigo/Dizziness	✓	✓	Gall Bladder/Pancreas		✓	Gonorrhea		✓
Vision Problems	✓	✓	Liver Problems		✓	Syphilis		✓
Hearing Problems		✓	Arthritis		✓	Lice, Crabs, Scabies		✓
Seizures		✓	Joint Muscle Problem		✓			
Strokes	✓	✓	Back/Neck Problem		✓	LMP		
Nervous Disorders		✓	Kidney Stones/Dz		✓	Date		
DT's		✓	Bladder/Kidney Infection		✓	Duration		
Heart Condition	✓	✓	Alcoholism		✓	Normal		
Angina/Heart Attack	✓	✓	Drug Abuse		✓	Regularity		
High Blood Pressure	✓	✓	Psychiatric History		✓	Gravida/Para		
Anemia/Blood Disorder		✓	Suicidal Thoughts**		✓	AB/Miscarriage		
Sickle Cell or Trait		✓	**Immediate M.H. Referral			Contraception		
Lung Condition	✓	✓	T.B.			Type:		
Asthma *		✓	PPD - date given: <u>4/24/06</u>					
*Peak Flow Reading		✓	RFA/LFA			Lab Tests - Dates	N	Ab
Bronchitis		✓	Date read: <u>4/24/06</u>			Diagnostic Profile II		
Emphysema		✓	Results: <u>0</u> mm			RPR		
Pneumonia		✓	Visual Acuity			Urine Dip Stick		
Diabetes	✓	✓	OD OS					
Hay Fever/Allergies		✓	OU <u>20/20</u> RX			EKG (@ age 35)		

Immunization History:

***HIV Medications:

Acute or Chronic Problem Noted: (Y) NRefer to Mid-Level or M.D. if yes.

[Signature]
RN or Mid-Level Signature

4/25/06
Date/Time

INTAKE HEALTH APPRAISAL

NAME: _____

AIS#: _____

D.O.B.: _____ R/S _____

HEALTH CLASSIFICATIONS:
(Circle One)

1 - No Restrictions

2 - Temporary Restrictions
See Special Needs Form3 - Permanent Restrictions
See Special Needs Form

4 - A&I (Aged & Infirm)

5 - Not Determined
Recheck _____

PLACEMENT:

General Population ()

Emergency Department ()

Isolation ()

Medical Observation ()

Other _____

REFERRAL:

CCC Placement ()

Clinic(s) _____
See MD/Mid-Level flow sheet
for clinic(s).

Medical ()

Dental ()

Mental Health ()

Other _____

When: () Immediately
() Next Sick Call

IMMUNIZATIONS ORDERED:

APPRAISAL	N	Abn/Comment
General Movement Deformity Pain, Bleeding Habit, Hygiene	✓	
Neuro Mental Status Intox Withdrawal, Tremor Neuro-Deficits	✓	
Skin Injury, Bruises, Trauma Jaundice Diaphoretic Rash, Lesions, Infestations Needle Marks Color, Turgor	✓	Tattoos - 1 Scar - 1
Head Normocephalic Atraumatic Hair, Scalp	✓	
Eyes Glasses/Vision Pupils Sclera, Conjunctiva	✓	
Ears Appearance Canals, TMs, Hearing	✓	
Nose Epistaxis Sinuses	✓	
Throat Teeth, Gums, Dentures Mouth, Tongue, Tonsils Airway	✓	
Neck C-Spine, Mobility Veins, Carotids Thyroid, Lymph Nodes	✓	
Chest Config. Ausc/Resp Cough/Sputum Breast/Masses	✓	
Heart Ausc Rate, Rhythm Murmurs, Ectopy	✓	
Abdomen Bowel Sounds Palp, G/R/T, Hernia	✓	
GU Flank Tenderness Bladder Tenderness/Distention	✓	
Back ROM, Spasm, Injury	✓	
Extremities Edema, Pulse	✓	
Genitals Injuries/Lesions		deferred
Pelvic Pap		
Rectal/Guicac (required @ 45 and up) Deferred/follow-up:		

Medications Ordered: _____

② 4/27/06
M.D. or Mid-Level Signature

Date/Time



PRISON
HEALTH
SERVICES
INCORPORATED

INTAKE SCREENING

Date: 4/21/06	AIS#: 110574		
Last Name: Marshall	First: Carl	Middle: Vincent	
Birthplace: Montgomery AL	DOB: 8/16/50	SS#: 210/126	
FEMALES: Pregnancy test: <u>N/A</u> (circle one) <u>Positive</u> Negative		B/P: 210/126 Temp: 98.8 Pulse: 96 Resp: 20 Weight: 241 FSBS: 179 If level > 200, repeat within 48 hours. Above 300 call M.D.	

Previous Hospitalizations/Surgeries/Major Illness/Current Illness: What? Where?

2 Heart Attacks 2 strokes, 98+200 Baptist South, TN

Previous Incarcerations (Date & Facility)

Kilby-97, NJ PM

Medications: <input type="checkbox"/> None <u>yes</u>	Special Diet (Prescribed) <u>Diabetic</u>
Allergies: <input type="checkbox"/> NKKA <u>Adrenaline, tetracycline, clindamycin</u>	Past Positive TB Skin Test (circle one) YES - (Complete TB Screening Form) <u>NO</u>

ANY INMATE WHO IS UNCONSCIOUS, SEMICONSCIOUS, ACTIVELY BLEEDING, IN ACUTE PAIN AND URGENTLY IN NEED OF MEDICAL ATTENTION SHOULD IMMEDIATELY BE REFERRED FOR EMERGENCY CARE.

CLINICAL OBSERVATIONS

1) Level of Consciousness: <input type="checkbox"/> Alert <input checked="" type="checkbox"/> Oriented; time, place, person <input type="checkbox"/> Lethargic <input type="checkbox"/> Stuporous <input type="checkbox"/> Comatose Describe:		3) Substance Abuse: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Suspected <input type="checkbox"/> Current intoxication/Abuse <input type="checkbox"/> Use <input type="checkbox"/> Withdrawal Symptoms <input type="checkbox"/> Drugs <input type="checkbox"/> Alcohol Describe- What kind? Amount/Frequency? • If confirmed Benzo use, then call M.D. If can not be confirmed, call M.D. Last Use: (Time/Date):	
2) General Appearance: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal 3) Signs of Trauma: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		4b) Affect/Mood: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Manic <input type="checkbox"/> Depressed <input type="checkbox"/> Euphoria <input type="checkbox"/> Flat <input type="checkbox"/> Emotionally Confused Describe:	
4a) Behavior/Conduct: <input checked="" type="checkbox"/> Calm <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Non-Violent <input type="checkbox"/> Agitated <input type="checkbox"/> Uncooperative <input type="checkbox"/> Violent <input type="checkbox"/> Manipulative <input type="checkbox"/> Disorganized Describe:		4c) Perceptions: <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input checked="" type="checkbox"/> Hearing Voices	
5a) Is there h/o actual suicide attempt? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 5c) Is there evidence?		5b) Does pt describe current suicidal thoughts or ideations? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 5d) High risk pt may become assaultive towards staff? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If ANY of the above in #5 are circled, staff MUST describe here, include previous history and dates: *Any abnormal observations #4 or 5 require immediate Mental Health Referral.		Triggers for Suicide Watch - Currently Suicidal - History of actual attempt - Fails to maintain control on Close Watch Y or N Triggers for Close Watch - Emotionally distraught and unable to regain composure by end of intake process - Actively hallucinating or not making any sense Y or N	
6a) Communication Difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 6c) Hearing Impairment: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		6b) Memory Defects: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 6d) Speech Difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
7) Physical Aids: <input type="checkbox"/> None <input checked="" type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Dentures <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Braces <input type="checkbox"/> Artificial Limb <input type="checkbox"/> Other			
8) Additional comments, complaints, symptoms: <input checked="" type="checkbox"/> None S) "Blurred vision" <input type="checkbox"/> O) Fever <input checked="" type="checkbox"/> Swollen Glands <input checked="" type="checkbox"/> Signs of Infection <input checked="" type="checkbox"/> Skin Intact <input checked="" type="checkbox"/> A) Vitals as above, CRAB x 4, no white cells noted. P) Contact Robbins, MD			

If known Diabetic * Call M.D. for order Initial Insulin given:

I have answered all questions truthfully. I have been told and shown how to obtain medical services. I hereby give my consent for health services to be provided to me by and through PRISON HEALTH SERVICES.

Inmate's Signature/Date

Health Provider Signature/Date



PRISON HEALTH SERVICES, INC.

DEPARTMENT OF CORRECTIONS

NOTIFICATION OF NEXT OF KIN

In the event of a serious injury or illness, I request the following person be notified:

LT. OSBORNE RUTLEDGE BROTHER
 MS. DORIS JOHNSON MOTHER
 Name Relationship
 281-5669
 284-1059
 FIELDCREST CT. Phone Number
 Street Address
 Montg., AL. AL. State
 City Zip Code
 [Signature] 110574 416-70-3380 04/21/06
 Inmate Signature AIS# SS# Date

 Witness Date

INMATE NAME (LAST, FIRST, MIDDLE)	AIS#	D.O.B.	RACE/SEX	FACILITY
Marshall, Carl	110574	8/6/50	B/M	1616